DOCUMENT RESUME

ED 464 994 UD 035 025

AUTHOR Aron, Laudan Y.
TITLE Health Care Coverage among Child Support-Eligible Children.
INSTITUTION Urban Inst., Washington, DC.
SPONS AGENCY Office of the Assistant Secretary for Planning and Evaluation (DHHS), Washington, DC.
PUB DATE 2002-05-00
NOTE 68p.
CONTRACT HHS-100-99-0003
AVAILABLE FROM For full text: http://www.urban.org.
PUB TYPE Reports - Research (143)
EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS *Child Health; *Child Support; Children; Employed Parents; *Health Insurance; Mothers; Socioeconomic Status
IDENTIFIERS Childrens Health Insurance Program; Medicaid; National Survey of Americas Families

ABSTRACT

Using data from the National Survey of America's Families (a nationally representative survey of the economic, social, and health characteristics of children, adults, and their families), this paper discusses health care coverage among child support eligible children. It begins with a detailed profile of child support eligible children living with their mothers, including their demographic and socioeconomic characteristics and their child support and health insurance characteristics. In addition to current health insurance status, it examines what types of health insurance coverage children have had over the prior year and how their health insurance status varies by child support award and receipt status and the mother's employment characteristics. The paper then examines what share of these children might have access to employer-sponsored health insurance through their mothers' employers whether or not they actually have this type of coverage. Finally, it asks what share is eligible for Medicaid and the State Children's Health Insurance Program, how much these programs can reduce the number of child support eligible children who are uninsured, and what opportunities and barriers are encountered by state officials in coordinating efforts to secure appropriate health insurance for children. (Contains 7 figures, 10 tables, and 30 references.) (SM)

Reproductions supplied by EDRS are the best that can be made from the original document.

ED 464 994

Health Care Coverage Among Child Support-Eligible Children

Laudan Y. Aron
The Urban Institute

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY

S. Brown
The Urban Institute

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

May 2002

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☑ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

This report was prepared for the Office of the Assistance Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services under contract number HHS-100-99-0003, Task Order No. 13. Thanks are due to Lynne Fender who served as the Task Order Manager and who conducted interviews with state officials on the opportunities and barriers to coordination among IV-D, Medicaid, and SCHIP, to Jennifer Haley who provided superb guidance on all health-related matters and constructed the variables on health care coverage, and to Anita Zuberi who provided very capable research assistance. The author would also like to thank Jennifer Burnszynski and Ann McCormick (Task Order Monitors) from ASPE, and Genevieve Kenney, Lisa Dubay, Laura Wheaton, Elaine Sorensen, Robert Lerman, and Linda Blumberg of the Urban Institute for their helpful reviews and comments. The analysis and opinions are those of the author and do not represent the official policies or positions of DHHS, the Urban Institute, or any of its funders or trustees.

THE URBAN INSTITUTE 2100 M STREET, N.W. / WASHINGTON D.C. 20037

BEST COPY AVAILABLE

JD 035 025

ERIC

Table of Contents

Tables and Figures

Health Care Coverage Among Child Support-Eligible Children

Most Americans rely on private employer-sponsored health insurance to pay for their medical expenses, but this type of coverage actually declined during 1980s and 1990s despite a strong economy and growing employment. Private health insurance coverage fell most sharply among children and near-poor families. As a result, there are now as many as 8.5 million children in the United States without health care coverage, and over 80 percent of these children are dependents of working parents (Kenney et al. 2000, Mills 2001, O'Brien and Feder 1998, United States General Accounting Office 1997). Children who lack health care coverage are much less likely to receive important health care services, including preventive care such as childhood immunizations (Hoffman and Schlobohm 2000).

Federal and state efforts are underway to secure more and better coverage for uninsured children through major expansions in publicly-funded programs (Health Care Financing Administration 1999, Scanlon 2001).[1] The most important expansion is the State Children's Health Insurance Program (SCHIP), which was enacted by Congress in 1997 to provide health care coverage to "targeted low-income children" (i.e., children with family incomes below the greater of 200 percent of the federal poverty level (FPL) or 150 percent of the state's Medicaid eligibility threshold). Like Medicaid, SCHIP was designed as a Federal/state partnership, and its goal is to expand health insurance to children whose families earn too much to be eligible for Medicaid, but not enough to purchase private insurance.[2] More recently, some states have expanded SCHIP eligibility beyond the 200 percent FPL limit, and others are considering covering entire families, not just children.

[1] The Health Care Financing Administration has since been renamed the Centers for Medicare and Medicaid Services.

[2] Under Federal law, states must provide Medicaid to low-income families with children who would have met the eligibility criteria for the Aid to Families with Dependent Children (AFDC) program on July 16, 1996, infants and children under age six with incomes at or below 133 percent of the Federal Poverty Level, children born after September 30, 1983 who have attained six years of age and have incomes at or below 100 percent of the Federal Poverty Level, children receiving federally-funded foster care or adoption assistance, and disabled children receiving Supplemental Security Income (SSI). States also have the option of providing Medicaid to children with family incomes above these mandatory levels.

The public health insurance expansions have been significant—almost 95 percent of all low-income uninsured children are now eligible for Medicaid or SCHIP—but many low-income children remain unenrolled (Broaddus and Ku 2000).[3] Major efforts are being made to boost enrollment by improving public education and outreach, and simplifying the application and enrollment process (Ross and Cox 2000, Perry et al. 2000).

Securing and retaining employer-based health insurance for children is especially challenging when those children live apart from one or both parents (Mills 2001, Edmunds and Coye 1998). National policies designed to address these challenges have focused on strengthening the public Child Support Enforcement Program (CSE).[4] This program, also known as "IV-D" because it is authorized in Part D of Title IV of the Social Security Act, was established in 1975 and was originally intended to reduce escalating welfare costs by recouping monies spent on single-parent families receiving public welfare and reducing the potential that others would need such assistance. The IV-D program helps parents legally establish a child's paternity (if needed), obtain court orders for financial support by non-resident parents, and regularly collect child support payments from non-resident parents. While some parents (e.g., those receiving Temporary Assistance for Needy Families) are *required* to cooperate with state child support enforcement agencies, IV-D services are available to *any* parent or guardian of a child support-eligible child; not all custodial parents choose to apply for services through the IV-D program. Over the years Congress has strengthened the IV-D program through a series of legislative and regulatory changes. Since 1984, when state child support agencies were first required to petition for the inclusion of medical support[5] as part of any child support order (when available to the non-custodial parent at reasonable cost), increasing the number of children in single-parent families with medical coverage has been a key component of all of these changes.

---

[3] This 95 percent figure may be an overestimate because Broaddus and Ku did not account for ineligibility among children who are non-citizens. Taking legal status into account, Dubay and colleagues (2002) find that about 85 percent of low-income uninsured are eligible for public health coverage.

[4] For a detailed history and description of the CSE program, see the Committee on Ways and Means (2000).

[5] The term "medical support" refers to the legal provision for payment of medical and dental bills (through family health insurance coverage or cash medical support). A medical child support order is usually the medical support component of a broader legal child support order.

In 1988, IV-D agencies were required to develop criteria for identifying existing child support cases with a high potential for inclusion of medical support and to petition for a modification of the order to include such support. Further barriers to securing health insurance through non-custodial parents were addressed in the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66). Enrolling and securing benefits for child support-eligible children were made less restrictive: insurers, for example, were prohibited from denying the enrollment of a child under the health insurance coverage of the child's parent on the grounds that the child was born out of wedlock, was not claimed as a dependent on the parent's Federal income tax return, or did not reside with the parent or in the insurer's service area.

Yet more changes affecting children's access to adequate medical support were enacted in the 1996 welfare reform legislation and the Child Support Performance and Incentive Act of 1998 (P.L. 105-200).[6] Currently, all child support orders enforced by state IV-D agencies must include a provision for health care coverage. If the non-custodial parent changes jobs and the new employer provides health coverage, the state must send notice of coverage to the new employer and the notice must serve to enroll the child in the health plan of the new employer. As many as 93 percent of current IV-D child support orders now appear to have provisions requiring medical coverage for dependent children, but dependent health care coverage through the non-custodial parent's employer often remains untapped (Office of the Inspector General 2000).

The potential for securing employer sponsored health insurance (ESI) coverage through the non-resident fathers has been examined by Laura Wheaton (2000). Drawing on data from the 1993 Survey of Income and Program Participation (SIPP), Wheaton found that half of non-custodial fathers who do not provide health insurance for their children do not have access to such coverage and that problems associated with costs, continuity of coverage, and geography can complicate the ability of those who do (or might be able to) provide their children with employer-sponsored coverage. Wheaton notes that the provision of employer-sponsored

[6] One major unintended consequence of the 1996 welfare reform law was the loss of Medicaid coverage by many individuals, the majority of whom were children (Families USA Foundation 1999).

coverage through a non-custodial father may work well when this coverage is both affordable and preferable to coverage available to the custodial family (by being more comprehensive, accessible, or continuous). Almost 70 percent of families with a child support order requiring the non-resident father to provide health insurance received such coverage in at least one month of 1993. Wheaton suggests that some of this high level of coverage may be the result of fathers being induced to provide coverage (by virtue of it being ordered). It is also possible, however, that the coverage reflects the fact that child support orders are more likely to have a health insurance requirement when fathers have access to health insurance for their children and this coverage is preferable to what is available to the custodial parent. Given the finding that many non-custodial fathers do not have access to family coverage, it is unlikely that simply requiring that more child support orders include health care provisions will significantly increase health insurance coverage among child support-eligible children. This is further supported by Wheaton's finding that non-resident fathers who provide health care coverage for a full year appear to be somewhat better off financially than those who provide coverage for only part of the year.

Some low-income children may be better off *without* coverage from a non-resident father if this coverage is not continuous. Children who do not live with their non-custodial parent and who have employer-sponsored insurance may still be eligible for SCHIP. States are required to provide coverage to children who do not have reasonable access to care. This protection is designed to provide relief for children who are not in close geographic proximity to the employer of a non-custodial parent and cannot receive treatment in the locality in which they reside due to service area and other restrictions. Some states require a waiting period before a child can become eligible. The SIPP data reveal substantial disruptions in coverage among children with insurance through their non-resident fathers: less than half of fathers providing health care coverage to their non-resident children provide coverage in every month, even though 86 percent of the fathers providing some coverage themselves had health care coverage every month of the year. Some of this disruption in coverage may be due to geographic distances between children and their non-resident fathers. Fathers whose locations were known and who lived in the same

state as their children were somewhat more likely to pay child support and provide health care coverage than were fathers living in states different from their children.

The proliferation of managed care and rising health care costs have challenged the traditional approach of requiring non-custodial parents to provide children with private health insurance when it is available through an employer. Health maintenance organizations (HMOs) and other new health insurance models often limit service areas and choice of provider, making geographic location and distance very important, especially when children live far away from their non-custodial parents. In addition, affordable health insurance is often not available to low-wage workers, many of whom are part-time or temporary workers (O'Brien and Feder 1998).

These are among the many challenges identified recently by the Medical Child Support Working Group, a joint U.S. Department of Health and Human Services and U.S. Department of Labor group established by the Child Support Performance and Incentives Act of 1998 (P.L. 105-200) to suggest improvements to medical child support enforcement. The Working Group was charged with identifying and addressing barriers to effective medical child support enforcement, and developing recommendations in six specific areas: (1) the National Medical Support Notice;[7] (2) priority of withholding from an employee's income, including medical support obligations; (3) coordination of medical child support with Medicaid and SCHIP; (4) alternatives to a medical support model focused exclusively on the non-custodial parent's health plan; (5) the standard for "reasonable cost" for medical child support; and (6) other measures to eliminate impediments to medical child support enforcement.[8]

The Working Group's report, *21 Million Children's Health: Our Shared Responsibility* (2000), establishes a new paradigm for medical support and makes over 75 recommendations in the areas

[7] The National Medical Support Notice is legal notice that provides a standardized means of communication between state child support enforcement agencies, employers, and administrators of group health plans regarding the medical support obligations of non-custodial parents.

[8] Much of this discussion is drawn directly from the Working Group's report. See Chapter 1, "Lack of Health Care Coverage—High Risk for Child Support-Eligible Children" in Medical Child Support Working Group (2000).

of federal legislation, regulation, and guidance; technical assistance and education; best practices; research and demonstrations; and administrative actions. The report recognizes that increasing the number of child support-eligible children with health care coverage is in the best interests of children, families, and the nation. It also promotes securing *private* dependent care coverage when such coverage is comprehensive, accessible, *and* affordable, while ensuring that transitions between private and public sources of coverage are as seamless as possible. The new paradigm to emerge from the Working Group is that *both* parents should be responsible for medical support and that—all other things equal—preference be given to the *custodial* parent as the source of such coverage:

> Coverage available to both parents should be considered in setting a medical support obligation. If only the custodial parent has coverage, that coverage should be ordered and the non-custodial parent should contribute toward the cost of such coverage. When both parents are potentially able to provide coverage, the coverage available through the custodial parent (with a contribution toward the cost by the non-custodial parent) should normally be preferred as it (1) is most likely to be accessible to the child, (2) involves less difficulty in claims processing for the custodial parent, provider, and insurer, and (3) minimizes the enforcement difficulties of the child support agency or private attorney responsible for the case" (p. 2-19).

Looking towards custodial parents seems quite appropriate given that ESI through *non-custodial* fathers can reduce the number of custodial families without private insurance by 2 to 18 percent (Wheaton 2000). But how much private coverage are custodial mothers able to provide? Using data from the National Survey of America's Families, this paper explores the extent to which children who are eligible for child support can and do secure private health insurance coverage through their *custodial* (or resident) mother,[9] and what shares of those without private insurance might be eligible for publicly-funded health insurance.[10] This paper also explores what

[9] Parents of children entitled to child support are often referred to as custodial or non-custodial parents. The custodial parent is the parent with legal custody and with whom the child lives. This report also uses the terms *resident* and *non-resident* parent to distinguish between the parent living *with* the child most of the year and the parent living *apart* from the child most of the year. To be comparable with a similar study of 1993 SIPP data (see Wheaton 2000), only child support-eligible children *living with their mothers* are examined in this report.

[10] Note that who provides health coverage and who pays for it are separate issues: even when a child is insured through a plan offered by the custodial parent's employer or a publicly-subsidized plan, the non-custodial parent can contribute towards the (premium) *costs* of this insurance.

opportunities and barriers exist to IV-D agencies coordinating with SCHIP and Medicaid program staff to enroll uninsured children in those public programs when parents are unable to provide their children with appropriate private coverage.

Using data from the NSAF, the analyses reported here begin with a detailed profile of child support-eligible children living with their mothers, including their demographic and socioeconomic characteristics, as well as their child support and health insurance characteristics. In addition to *current* health insurance status, we examine what types of health insurance coverage children have had over the prior year, and how their health insurance status varies by child support award and receipt status and the mother's employment characteristics. The paper then examines what share of these children *might* have access to employer-sponsored health insurance through their mothers' employers whether or not they actually have this type of coverage. Finally, we ask what share is eligible for Medicaid and SCHIP, how much these programs can reduce the number of child support-eligible children who are uninsured, and what opportunities and barriers are encountered by state officials in coordinating efforts to secure appropriate health insurance for children. The following section describes the National Survey of America's Families, a data source well suited to address many of the questions of this study.

Data from the National Survey of America's Families

The 1999 National Survey of America's Families (NSAF) is a nationally representative survey of the economic, social, and health characteristics of children, adults under the age of 65, and their families (Wang et al. 2000). Interviews for the 1999 round of the survey were conducted for over 42,000 households, yielding detailed information on more than 109,000 non-elderly people.

The NSAF covers a wide range of issues related to family well-being, including: (1) *economic security* (including income, employment, earnings, participation in education and training programs, participation in welfare programs, child support receipt and payment, food security, and housing and economic hardship), (2) *health and health care* (which includes health insurance coverage, health care use and access, health status and activity limitations, and reasons

for not participating in public health care programs), (3) *family environment* (which includes family structure and household composition, contact with non-custodial parents, parent psychological well-being, parent stress, and parent volunteer and religious activity), and (4) *children's well-being* (which includes educational and cognitive stimulation, behavior problems, child care arrangements, school engagement, and social and other developmental activities).

In households with children under age 18, up to two children were sampled for in-depth study: one under the age of 6 and another between the ages of 6 and 17. Interviews were conducted with the adult in the household who was most knowledgeable about the health care, education, and well-being of the sampled child(ren). In 95 percent of the cases, the adult answering questions about a child was the biological, adoptive, or step-parent of the child in question. In general, one adult (usually the mother) answered questions about both children, but in some circumstances, two different adults answered questions for the two sampled children. In all, the 1999 survey consisted of 29,917 extended interviews with the primary caregivers of children, netting information on almost 36,000 children.[11] In this study, the unit of analysis is an NSAF *child.*

The actual survey was conducted between February and October 1999. Some questions covered the family's circumstances at the time of the survey, while others covered the previous 12 months or the prior (1998) calendar year. The survey oversampled families with incomes below 200 percent of the federal poverty level, giving one even greater flexibility in studying the circumstances of low-income individuals and their families.[12]

Child Support-Eligible Children from the NSAF

Children are eligible for child support when their parents divorce, separate, or decide not to marry or live together. Most children (almost 80 percent) who live apart from a parent, live with

[11] For the few cases where the most knowledgeable adult was not the child's mother (or step-father), some data on the mother's employment and health insurance characteristics are missing.
[12] In 1998, the federal poverty guideline was $10,850 for a family of two, $13,650 for a family of three, and $16,450 for a family of four (*Federal Register* 1998).

their biological or adoptive mothers.[13] These children—who live with their biological or adoptive mothers and *not* with their biological or adoptive fathers (9,189 sample children)—comprise the NSAF sub-sample used for this analysis. Nationally, they represent 17.9 million children—or 24.9 percent of all children in the country.

To ensure that the findings of this study are comparable to the SIPP study by Wheaton (2000), two groups of child support-eligible NSAF children are not included in this study. The first is children living with a resident father rather than a mother (these 2.4 million children account for 11 percent of all children living apart from at least one parent).[14] A preliminary examination of these children indicated that they are very different from their counterparts living with their mothers.

The observed differences quite large, but they are also related to the basic questions underlying this study regarding custodial parents' ability to provide employer-sponsored health insurance (ESI) and, in the absence of such coverage, children's eligibility for government-sponsored health care coverage. Children living with a custodial father, for example, are more likely than children living with a custodial mother to be covered by ESI (70 versus 50 percent). They are also less likely than those living with their mothers to have family incomes below 200 percent of the federal poverty level (36 versus 63 percent) and therefore less likely to be receiving government benefits such as TANF, SSI, Food Stamps, Medicaid, or SCHIP (17 percent versus 47 percent).[15] Combining both groups of children might obscure our understanding of child

[13] Not all child support-eligible children live in single-parent families: almost one in five live in married step-parent families, and many have (half- or step-) siblings who are not eligible for child support.

[14] When these 2.4 million children are added to 17.9 million living with their mothers, the total is 20.3 million child support-eligible children (in 1999)—a figure very close to the estimate of 21 million children child support-eligible children (in 1996) used by the Medical Child Support Working Group (2000). Their estimate was derived from the Child Support Supplement to the 1996 Current Population Survey (CPS).

[15] Other differences between child support-eligible children living with their fathers those living with mothers include (figures are weighted to be nationally representative): resident parent works (90 versus 71 percent); child covered by a child support order (37 versus 53 percent); family receives any child support (21 versus 46 percent); and child has no contact with non-resident parent (11 versus 28 percent).

support-eligible children who live with their mothers—the most common living arrangement of child support-eligible children.

A second group of children dropped from the sample used in this analysis is the 2.2 million children living with neither parent. These children also have unique circumstances, and they account for another 10 percent of all child support-eligible children.

Limitations of NSAF for the Purposes of this Study

NSAF offers many advantages for studying the health insurance characteristics of child support-eligible children, but there remain some important limitations. Despite the wealth of information on actual and potential sources of health insurance coverage, the NSAF data do not address the costs, accessibility, or quality of such coverage.[16] These are critical dimensions that any family must consider when deciding among different sources of coverage or choosing any single type coverage. Indeed, in their comprehensive report on this issue, the Medical Child Support Working Group repeatedly refers to "appropriate" health coverage which they define as coverage that is *comprehensive, accessible*, and *affordable*. This study cannot address these important aspects of children's health insurance coverage.[17]

A less important limitation of the NSAF health insurance data is the inability to identify policyholders who live outside the respondent's household. So, for example, if a child support-eligible child has health insurance through his/her non-resident parent, then all we know is that the source of coverage is "someone outside the household" and we must *assume* that this person is the non-resident parent.

The NSAF also has no information on which individuals are formally involved in the Child Support Enforcement or IV-D program. This is not as limiting as it might seem. First, all families receiving public welfare benefits are required to participate in the IV-D program, and

[16] It is very difficult to obtain reliable data on these topics through household surveys.
[17] For a more thorough review of trends in the costs and benefits of job-based health insurance plans, see Rice et al. (1998) and Hoffman and Schlobohm (2000).

children in [these] families receiving welfare are very easy to identify in the NSAF sample. Second, any family wanting child support enforcement services—to locate an absent parent, establish paternity, establish support obligations, or enforce a child support order—is entitled to such assistance from their IV-D agency and so by definition, all cases in our sample are potential IV-D cases.[18] According to estimates based on the 1998 Current Population Survey, about 60 percent of all child support-eligible families receive services through the IV-D system (Lyon 2002).

The following sections of this paper report on the basic demographic and socioeconomic characteristics of the children living with their mothers in the child support-eligible NSAF sample, followed by a more in-depth examination of their health insurance characteristics. Also included are estimates of children's potential access to employer-sponsored health insurance and their eligibility for Medicaid and SCHIP. The final section compares our findings with those of Wheaton's study (2000) estimating the potential for securing health insurance through non-resident fathers and presents some of the policy implications of the results.

Demographic and Socioeconomic Characteristics of Child Support-Eligible Children Living with Their Mothers

The demographic and socioeconomic characteristics shown in Table 1 reveal that child support-eligible children living with their mothers are diverse. They span all ages, with about half of them being under the age of 10 (about 20 percent are under age 5 and another 30 percent are aged 5 to 9). Thirty percent of the children are aged 10 to 14 and the remaining 17 percent are age 15 and older. Almost half (47 percent) of these children are white non-Hispanic, 31 percent are black non-Hispanic, 18 percent are Hispanic (of any race), and the remaining 4 percent of some other race/ethnicity. Black and Hispanic children make-up even larger shares—almost 60 percent—of low-income child support-eligible children living with their mothers (those in households below 200 percent of the federal poverty level). Child support-eligible children

[18] OCSE defines a child support case as "a parent (mother, father, or putative father) who is now or eventually may be obligated under law for the support of a child or children receiving services under the title IV-D program" (Office of Child Support Enforcement 2000).

Table 1
Socioeconomic and Demographic Characteristics of Child Support-Eligible Children Living with Their Mothers

	All Children		Less than 200% FPL		200% FPL and above	
	(millions)	%	(millions)	%	(millions)	%
Total	17.9	100%	11.3	100.0%	6.6	100.0%
Child's Age						
under 5 years	3.8	21.2%	2.7	24.1%	1.1	16.3%
5-9 years	5.6	31.1%	3.7	32.5%	1.9	28.7%
10-14 years	5.5	30.4%	3.3	29.2%	2.2	32.6%
15 years and older	3.1	17.3%	1.6	14.2%	1.5	22.5%
Child's Race/Ethnicity						
white non-Hispanic	8.4	47.1%	4.2	37.3%	4.2	63.7%
black non-Hispanic	5.6	31.1%	4.2	37.0%	1.4	20.9%
Hispanic	3.3	18.2%	2.5	22.1%	0.8	11.5%
other	0.7	3.7%	0.4	3.6%	0.3	3.8%
Family Status						
single mother	14.1	78.8%	10.2	89.7%	4.0	60.2%
two parent family	3.8	21.2%	1.2	10.3%	2.6	39.8%
Mother's Age						
under 20 years	0.3	1.9%	0.3	2.3%	0.1	1.2%
20-24 years	1.7	9.8%	1.3	11.6%	0.4	6.6%
25-29 years	3.2	17.8%	2.3	19.9%	0.9	14.2%
30 years and older	12.6	70.5%	7.5	66.1%	5.1	78.1%
Mother's Marital Status						
never-married	5.2	29.5%	4.1	37.2%	1.0	16.1%
married	4.2	23.7%	1.4	12.8%	2.7	42.5%
separated/divorced	8.0	45.3%	5.4	48.2%	2.6	40.3%
widowed	0.1	0.8%	0.1	1.1%	0.0	0.4%
unknown	0.1	0.7%	0.1	0.7%	0.1	0.8%
Number of Children in Family						
one child	4.5	25.1%	2.1	18.5%	2.4	36.4%
two children	6.5	36.0%	3.8	33.6%	2.7	40.2%
three or more children	7.0	38.9%	5.4	48.0%	1.6	23.4%
Mother's Educational Attainment						
less than high school	2.9	16.7%	2.7	24.4%	0.2	3.7%
high school diploma/GED	6.0	34.3%	4.1	37.1%	1.9	29.5%
some voc/tech or college	8.5	49.0%	4.2	38.1%	4.3	66.8%
Mother's Employment Status						
currently employed	12.4	70.8%	6.8	61.5%	5.6	86.8%
full-time (35+ hrs)	8.9	50.9%	4.5	41.2%	4.3	67.8%
half-time (20-34 hrs)	2.1	11.8%	1.4	12.8%	0.6	10.1%
part-time (1-19 hrs)	0.5	2.8%	0.4	3.2%	0.1	2.1%
self-employed	0.9	4.9%	0.4	3.9%	0.4	6.6%
not currently employed	5.1	29.2%	4.3	38.5%	0.9	13.2%
looking for work	1.8	10.4%	1.6	14.3%	0.2	3.6%
not in the labor force	3.3	18.9%	2.7	24.2%	0.6	9.6%
Family Income (% FPL)						
below federal poverty level	6.8	37.8%	6.8	59.8%		
100-199% FPL	4.6	25.4%	4.6	40.2%		
200-299% FPL	3.1	17.3%			3.1	47.0%
at or above 300% FPL	3.5	19.6%			3.5	53.0%
Median Family Income (dollars)		$22,300		$13,370		$50,420
Mean Family Income (dollars)		$30,982		$14,732		$58,792
Family Currently Receives Government Benefits						
yes	8.4	46.6%	7.4	64.9%	1.0	15.2%
no	9.6	53.4%	4.0	35.1%	5.6	84.8%
Family Currently Receives TANF						
yes	2.9	16.2%	2.7	24.0%	0.2	2.8%
no	15.0	83.8%	8.6	76.0%	6.4	97.2%

Notes: Sample consists of 9,189 children living with their biological/adoptive mothers and *not* living with their biological/adoptive fathers. Children in two parent families are those with mothers who have (re)married someone other than the child's father. Government benefits include TANF, Food Stamps, SSI, Medicaid, and SCHIP. Percent figures may not sum to 100 due to rounding.

Source: Urban Institute analysis of the 1999 National Survey of America's Families (NSAF)

living with their mothers in low-income households are also slightly younger than other child support-eligible children living with their mothers.[19]

The majority (close to 80 percent) of child support-eligible children living with their mothers live in single-parent families.[20] The remaining 21 percent are in two-parent families, meaning that the child's mother has (re)married and there is a step-father present. As the top portion of Figure 1 illustrates, children in single-parent custodial mother families are more than twice as likely as those in two-parent custodial mother families to be low-income (i.e., have a family income under 200 percent of the federal poverty level). Seventy-two percent of children in single-mother custodial families are low-income compared to 31 percent of children in two-parent custodial mother families. Another way of looking at the relationship between family status and income is to consider what share of low- and higher-income families are single- versus two-parent (see the lower portion of Figure 1). Low-income custodial mother families are much more likely than higher-income families to be single-mother families (90 percent versus 60 percent).

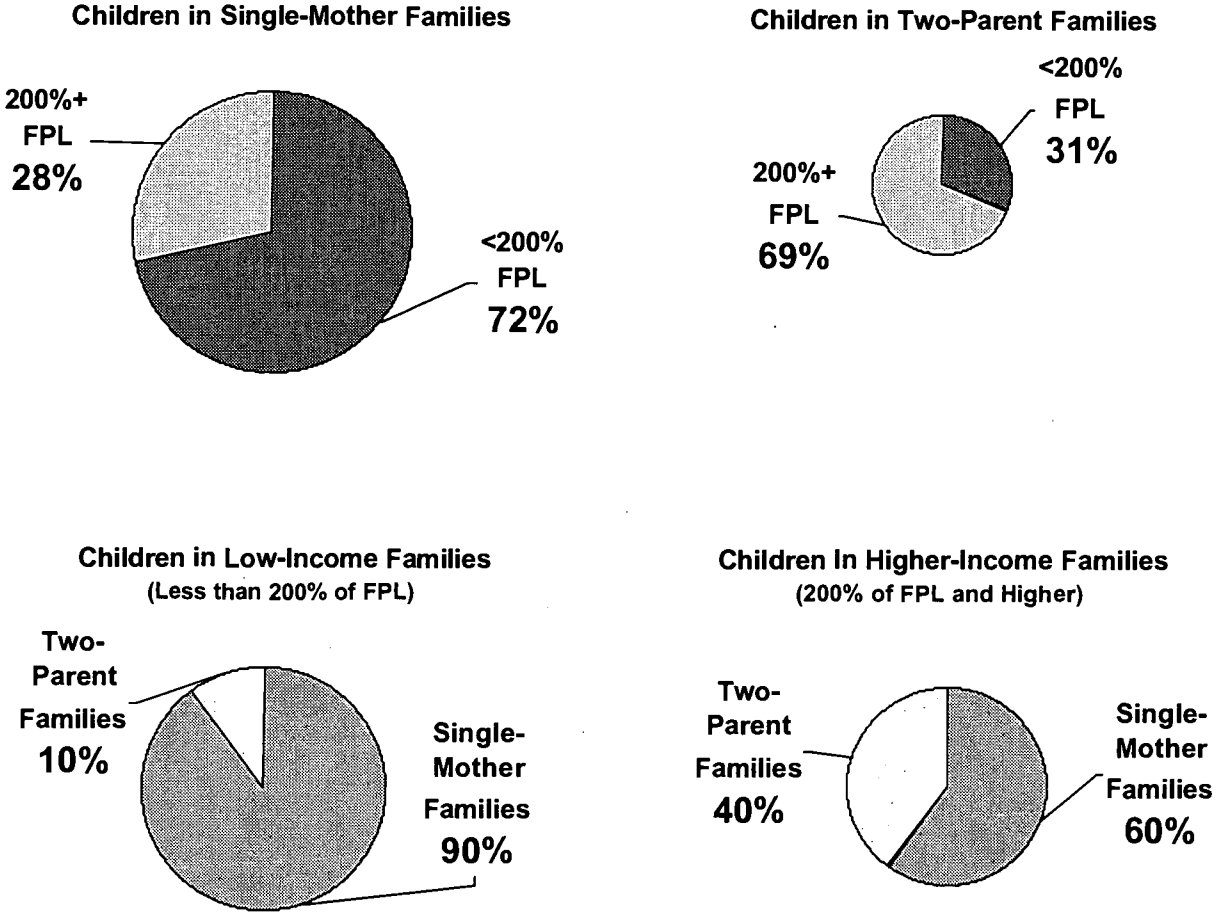
The data on mothers' detailed marital status, also reported in Table 1, reveal that almost half (45 percent) of child support-eligible children living with their mothers are living with mothers who are divorced or separated, just under a third (30 percent) are with never married mothers, and a quarter (24 percent) are with married mothers. One quarter of children eligible for child support living with their mothers are in single-child families, 36 percent are in two-children families, and the remaining 39 percent are in families with three or more children.[21] Children with family incomes below 200 percent of the federal poverty level are more than twice as likely as other

[19] Unless noted otherwise, all statements in this report comparing differences among groups of children in the share with a given characteristic have been tested for statistical significance and have been found to be significant at the 99 percent confidence level (using α=.01).

[20] One in eight of the children in the single-mother group (10 percent of the full weighted sample) are actually living with the mother and her male partner. One recent study of children's living arrangements using 1997 and 1999 NSAF data reveals that nationally single parenting is becoming less common while cohabiting is becoming more common, and that these trends are most pronounced among families living below 200 percent of the federal poverty level (Acs and Nelson 2001).

[21] Note that just because one child in a family is eligible for child support does not mean that all of the children in that family are. Child support-eligible children may have half- or step-siblings who are not themselves eligible for child support.

Figure 1
Family Status and Income Among Child Support-Eligible Children
Living with Their Mothers



Source: Urban Institute analysis of the 1999 National Survey of America's Families (NSAF)

child support-eligible children living with their mothers to have a mother who is never married (37 percent compared to 16 percent of other children), and they are much less likely to have a mother who is married (13 percent compared to 43 percent). They are also much less likely to be the only child in the family (19 compared to 36 percent) and much more likely to have more than one sibling (48 compared to 23 percent). These findings are consistent with the expectation that families with more adults and/or fewer children are generally better off economically.

The mothers' age, educational attainment, and employment characteristics are also shown in Table 1. A small share (less than 2 percent) of child support-eligible children living with their mothers have very young mothers under age 20, just under 30 percent have mothers who are in their twenties, and just over 70 percent have mothers age 30 and older. Almost half of children eligible for child support living with their mothers have mothers with schooling beyond the high school level. Another third (34 percent) have mothers with a high school diploma or its equivalent, and the remaining 17 percent have mothers who have not completed high school. There are large differences in mothers' educational attainment by family income. Compared to their higher-income counterparts, children in low-income households are much more likely to have mothers who have not completed high school (24 versus 4 percent) and much less likely to have mothers with schooling beyond the high school level (38 versus 67 percent).

Over 70 percent of child support-eligible children living with their mothers have mothers who are currently employed, and in most cases they are employed full-time. Very small shares of children have mothers who are employed less than half time or are self-employed (less than 5 percent each). Ten percent of children have mothers who are unemployed—not employed but looking for work. There are large differences in these employment characteristics by income. Children with family incomes below 200 percent of poverty are more likely than other children to have mothers who are not in the labor force (24 versus 10 percent), and they are less likely to have mothers who are currently employed (62 versus 87 percent) or employed full-time (41 versus 68 percent).

Table 2

Child Support Characteristics of Child Support-Eligible Children Living with Their Mothers

	All Children		Less than 200% FPL		200% FPL and above	
	(millions)	%	(millions)	%	(millions)	%
Total	17.9	100.0%	11.3	100.0%	6.6	100.0%
Paternity Established						
yes	15.7	87.7%	9.6	85.1%	6.1	92.0%
no	2.2	12.3%	1.7	14.9%	0.5	8.0%
Child Support Awarded						
yes	9.5	53.5%	5.3	47.3%	4.2	64.1%
no	8.2	46.5%	5.9	52.7%	2.4	35.9%
Any Child Support Received						
yes	8.2	45.5%	4.3	38.3%	3.8	57.9%
no	9.8	54.5%	7.0	61.7%	2.8	42.1%
Child Support Paid in Past 12 Mos.						
full amount	4.5	25.2%	2.0	18.3%	2.4	37.0%
partial amount	1.9	10.9%	1.1	9.9%	0.8	12.6%
none	3.1	17.4%	2.1	19.0%	1.0	14.6%
no child support order	8.2	36.5%	5.9	52.8%	2.3	35.7%
Any Financial Contributions from Nonresident Father in Past 12 Mos.						
yes	10.0	55.6%	5.6	49.2%	4.4	66.6%
no	8.0	44.4%	5.8	50.8%	2.2	33.4%
Frequency of Contact with Nonresident Father in Past 12 Mos.						
more than once a week	3.3	18.4%	2.1	18.9%	1.2	17.6%
about once a week	1.4	8.1%	0.8	7.3%	0.6	9.6%
1-3 times per month	2.6	14.3%	1.5	13.6%	1.0	15.6%
1-11 times per year	3.6	20.1%	2.2	19.8%	1.4	20.7%
not at all	5.0	28.1%	3.4	30.5%	1.6	24.0%
other	1.9	10.9%	1.1	9.9%	0.8	12.5%

Notes: Sample consists of 9,189 children living with their biological/adoptive mothers and *not* living with their biological/adoptive fathers. Percent figures may not sum to 100 due to rounding.

Source: Urban Institute analysis of the 1999 National Survey of America's Families (NSAF)

order are all elements of a formal child support enforcement system and are legally enforceable. Some couples may make their own financial arrangements bypassing this system altogether. For example, some have joint physical custody or share parenting in lieu of a child support award, some parents do not pursue financial support, and sometimes step-parents assume parental responsibility without adopting the child. Others who *are* covered by legal child support orders may want to bypass the system for other reasons. Recall that parents receiving TANF are required by law to cooperate with state child support enforcement (or IV-D) agencies and must assign their rights to child support income over to the state while receiving government benefits. Some fathers may make informal financial contributions directly to the mother to prevent the state from retaining it, and some fathers may contribute funds over and above what they are legally obligated to pay.

The basic paternity establishment and child support characteristics of child support-eligible NSAF children residing with their mothers are shown graphically in Figure 2. Almost 88 percent of these children have legally established paternity (the first step needed to secure a child support order), and 54 percent of them (61 percent of those with paternity established) have a legal child support award. Thirty-six percent of children eligible for support living with their mothers have *any* child support paid on their behalf and 25 percent receive the full amount owed them.[24]

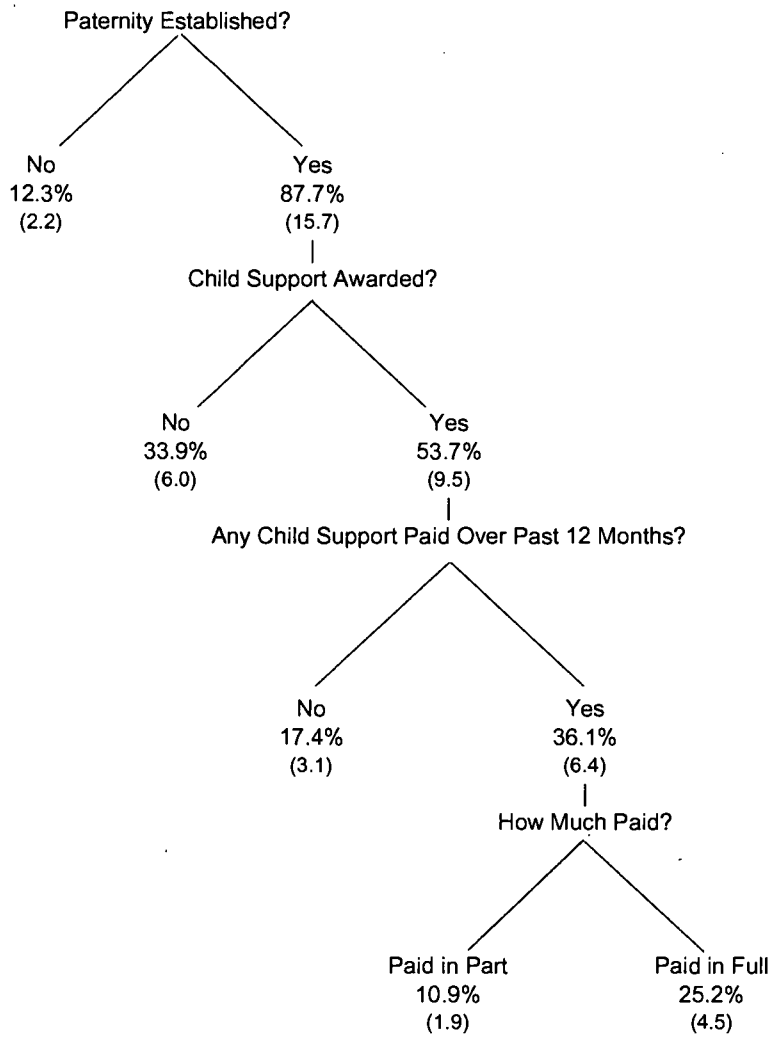
Table 2 also includes a number of other measures relating to non-resident fathers of child support-eligible children. Whatever their formal child support situation, well over half of child support-eligible children living with their mothers (56 percent) received some type of financial contribution from their fathers within the preceding year.[25] Child support-eligible children living with their mothers also have varying degrees of contact with their non-resident fathers. Over one-quarter (28 percent) of child support-eligible children living with their mothers have had no contact with their non-resident fathers in the past 12 months, but an equal share of children see

[24] These figures refer to payments of child support owed over the preceding 12 months. The share of children *currently* receiving any child support is higher: 46 percent of all children (or 85 percent of children with a current award).

[25] Recall that this information is reported by the resident parent and that any financial assistance paid by the non-resident parent but retained by the state would not be reflected in these data.

Figure 2

Child Support Status of Child Support-Eligible Children Living with Their Mothers
(numbers in millions)



Source: Urban Institute analysis of the 1999 National Survey of America's Families (NSAF)

their fathers one or more times per week. Almost 15 percent of children see their fathers one to three times per month and 20 percent see their fathers less than once a month.[26]

Important differences in children's child support characteristics emerge when these are examined separately by family income (see Table 2). Children with family incomes below 200 percent of the federal poverty level are much less likely than other children to have positive child support outcomes: they are less likely to have paternity established (85 percent compared to 92 percent), less likely to be covered by a child support award (47 percent compared to 64 percent), less likely to be currently receiving any child support (38 percent compared to 58 percent), and less likely to have received the full amount of child support due over the preceding 12 months (18 percent compared to 37 percent).

Although low-income children are less likely than the higher-income children to have received *any* financial contribution from their non-resident fathers (49 percent compared to 67 percent), their frequency of contact with this parent is much the same. The share of children with no contact with their non-resident father is slightly higher among low-income children (31 compared to 24 percent), but among the remaining children, the frequency of contact is quite similar: just over a quarter see their non-resident fathers once a week or more, about 15 percent see their fathers between one and three times per month, and 20 percent see them between one and eleven times a year.

A more detailed profile of the employment characteristics of the mothers of child support-eligible children living with their mothers is shown in Table 3.[27] Among the children with employed mothers, a substantial majority (88 percent) have mothers who work for an employer rather than being self-employed. Close to 46 percent of these children have mothers who work for a private employer and 12 percent have mothers who are employed by a government agency (they account for 65 and 16 percent, respectively, of children with *working* mothers). Overall,

[26] Contact between a non-resident father and his child is affected by many factors including distance between parent and child; particulars of the visitation agreement; and desire of the child, mother, and father for contact to occur.

[27] Recall that the basis of these numbers is a child support-eligible *child*, not his/her mother.

Table 3
Mothers' Employment Characteristics of Child Support-Eligible Children Living with Their Mothers

	All Children			Less than 200% FPL			200% FPL and above		
		% of children			% of children			% of children	
	(millions)	All	w/working mothers	(millions)	All	w/working mothers	(millions)	All	w/working mothers
Employment Status of Mother									
currently employed	12.4	70.8%	100.0%	6.8	61.5%	100.0%	5.6	86.8%	100.0%
full-time (35+ hrs)	8.9	50.9%	72.3%	4.5	41.2%	67.4%	4.3	67.8%	78.2%
half-time (20-34 hrs)	2.1	11.8%	16.8%	1.4	12.8%	20.9%	0.6	10.1%	11.7%
part-time (1-19 hrs)	0.5	2.8%	4.0%	0.4	3.2%	5.3%	0.1	2.1%	2.4%
self-employed	0.9	4.9%	7.0%	0.4	3.9%	6.4%	0.4	6.6%	7.7%
not currently employed	5.1	29.2%		4.3	38.5%		0.9	13.2%	
looking for work	1.8	10.4%		1.6	14.3%		0.2	3.6%	
not in the labor force	3.3	18.9%		2.7	24.2%		0.6	9.6%	
Employment Type of Mother									
working for employer only	10.9	62.2%	87.9%	6.1	55.2%	89.7%	4.8	74.4%	85.7%
self-employed only	0.9	4.9%	6.9%	0.4	3.9%	6.3%	0.4	6.5%	7.5%
both	0.6	3.6%	5.1%	0.3	2.3%	3.8%	0.4	5.8%	6.7%
neither	0.0	0.1%	0.1%	0.0	0.1%	0.1%	0.0	0.0%	0.0%
not working	5.1	29.2%		4.3	38.5%		0.9	13.2%	
Employer Type of Mother									
government	2.0	11.5%	16.3%	1.0	9.4%	15.3%	1.0	15.1%	17.4%
private company	8.0	45.8%	64.7%	4.5	40.9%	66.5%	3.5	54.3%	62.5%
non-profit organization	1.2	6.8%	9.6%	0.6	5.5%	9.0%	0.6	8.9%	9.8%
other	1.2	6.7%	9.4%	0.6	5.7%	9.2%	0.5	8.5%	10.3%
not working	5.1	29.2%		4.3	38.5%		0.9	13.2%	
Occupation of Mother									
management/professional/tech	3.8	21.8%	30.8%	1.2	11.0%	17.9%	2.6	40.5%	46.6%
sales	1.5	8.6%	12.2%	0.9	8.5%	13.8%	0.6	8.9%	10.3%
administrative support/clerical	2.6	15.0%	21.2%	1.5	13.2%	21.5%	1.2	18.2%	20.9%
services	2.8	16.1%	22.7%	2.2	19.7%	32.0%	0.6	9.9%	11.4%
other	1.6	9.2%	13.0%	1.0	9.2%	14.9%	0.6	9.3%	10.7%
not working	5.1	29.2%		4.3	38.5%		0.9	14.2%	
Industry of Mother									
agriculture/forestry/public admin	0.6	3.5%	5.0%	0.3	2.6%	4.2%	0.3	5.1%	5.8%
construction	0.1	0.7%	0.9%	0.1	0.5%	0.8%	0.1	1.0%	1.2%
manufacturing	1.5	8.7%	12.3%	0.8	7.2%	11.7%	0.7	11.4%	13.2%
transport/comm/public utilities	0.6	3.6%	5.0%	0.2	1.9%	3.2%	0.4	6.3%	7.3%
wholesale/retail trade	2.4	13.6%	19.3%	1.6	14.4%	23.4%	0.8	12.4%	14.3%
finance/insurance/real estate	0.9	4.9%	6.9%	0.4	3.2%	5.2%	0.5	7.9%	9.1%
services	6.2	35.4%	50.0%	3.5	31.5%	51.3%	2.7	42.1%	48.5%
employed, missing industry	0.1	0.3%	0.5%	0.0	0.2%	0.3%	0.0	0.5%	0.6%
not working	5.1	29.2%		4.3	38.5%		0.9	13.2%	
Firm Size (No. People at Work Place)									
under 10 people	1.4	8.3%	11.8%	0.8	7.2%	11.9%	0.6	10.1%	11.7%
10-24 people	1.5	8.5%	12.1%	0.9	8.4%	13.8%	0.6	8.7%	10.0%
25-99 people	2.2	12.6%	17.8%	1.2	11.1%	18.2%	1.0	15.1%	17.4%
100-499 people	2.4	13.8%	19.6%	1.4	12.4%	20.3%	1.0	16.2%	18.7%
500 people or more	1.6	9.5%	13.5%	0.8	7.2%	11.8%	0.9	13.4%	15.5%
unspecified	3.1	17.7%	25.2%	1.6	14.6%	23.9%	1.5	23.2%	26.7%
not working	5.1	29.6%		4.3	39.1%		0.9	13.4%	
Years with Current Employer									
less than 1 year	3.2	19.2%	27.9%	2.3	21.8%	36.6%	0.9	14.6%	17.0%
1-7 years	5.9	35.8%	52.0%	3.2	30.0%	50.4%	2.7	46.1%	53.9%
over 7 years	2.3	13.9%	20.2%	0.8	7.7%	13.0%	1.5	24.9%	29.1%
not working	5.1	31.1%		4.3	40.5%		0.9	14.4%	

Notes: Sample consists of 9,189 children living with their biological/adoptive mothers and *not* living with their biological/adoptive fathers. Percent figures may not sum to 100 due to rounding.

Source: Urban Institute analysis of the 1999 National Survey of America's Families (NSAF)

the children have mothers who work in managerial, professional, and technical jobs (22 percent), service jobs (16 percent), and administrative support and clerical jobs (15 percent).

More than a third of child support-eligible children living with their mothers have mothers with jobs in the service industry (35 percent), followed by jobs in the wholesale and retail trade industries (14 percent) and manufacturing (9 percent). The mothers of child support-eligible children living with their mothers also work in firms of varying sizes: the numbers of employees at the mother's work site ranges from fewer than 10 people (8 percent of child support-eligible children living with their mothers) to 500 people or more (10 percent of child support-eligible children living with their mothers).[28] Tenure at these jobs also varies. Over a third of child support-eligible children living with their mothers (52 percent of those with working mothers) have mothers who have been at their jobs between one and seven years. Almost one in five children (28 percent of those living with working mothers) have mothers who have been at their jobs for less than a year, and the remaining 14 percent (20 percent of those living with working mothers) have been at their jobs for more than seven years.

Differences by income are also evident from Table 3. The most important difference is that children in low-income households are more likely to have mothers who are not employed at all: 39 percent compared to 13 percent of children in higher-income households. Among children with mothers who do work, low-income children are more likely to have mothers who work in service occupations (32 percent compared to 11 percent of children in higher-income households) and less likely to work in managerial, professional, and technical jobs (18 percent compared to 47 percent). There are also large differences in job tenure, with children in low-income households being more likely to have mothers who have been at their current job for less than one year (37 percent of low-income children with working mothers compared to 17 percent of higher-income children with working mothers) and much less likely to have mothers who have been at their jobs for more than seven years (13 and 29 percent, respectively).

[28] This measure is the number of people working at the place (or location or site) where the respondent works. For firms with more than one location, it underestimates true firm size.

Health Insurance Coverage Characteristics of Child Support-Eligible Children Living with Their Mothers

NSAF respondents were asked a series of questions about their family's health insurance coverage *at the time of the survey*, including a question that confirmed the absence of insurance coverage for household members originally identified as not having any type of coverage. Responses to these questions reflect current (i.e., point in time) health insurance status and were classified into one of the following four categories: (1) employer-sponsored health insurance (ESI) (includes coverage from a current or former employer or union and those receiving coverage under the CHAMPUS or other military programs), (2) Medicaid/SCHIP/state (includes coverage through Medicaid, SCHIP programs, or other state-financed health insurance programs),[29] (3) other (includes coverage through Medicare, privately purchased coverage, and other coverage that is not classifiable elsewhere), and (4) uninsured. Health insurance status was defined using a hierarchy: individuals with both ESI and some other form of coverage were classified as having ESI. Those without ESI but with Medicaid/SCHIP/state coverage were classified as having Medicaid/SCHIP/state coverage.[30]

Half of child support-eligible children living with their mothers are currently covered by ESI (see Table 4). The sources of this coverage are as follows: the resident mother (26 percent), the non-resident father (13 percent), a step-father (7 percent), and another adult in the child's household (4 percent). Another third of the full sample of child support-eligible children living with their mothers have Medicaid, SCHIP, or some other type of state-sponsored coverage, and 3 percent have some type of insurance other than ESI or Medicaid/SCHIP/state coverage. Finally, about 15 percent of the children are uninsured.

Wheaton (2000) found substantially higher rates of ESI coverage through non-custodial fathers (24 versus 13 percent in this analysis) and lower rates of being uninsured (6 percent versus 15

[29] For current health insurance status, Medicaid, SCHIP, and other state-financed programs have been combined into a single category because these programs are often indistinguishable in household survey data such as NSAF. This is because of Medicaid expansions under SCHIP and because in some states, Medicaid and SCHIP programs have the same names.

[30] About 2 percent of the full 1999 weighted NSAF sample reported having more than one type of health insurance coverage.

Table 4
Current Health Insurance Coverage of
Child Support-Eligible Children Living with Their Mothers

	All Children		Less than 200% FPL		200% FPL and above	
	(millions)	%	(millions)	%	(millions)	%
Total	17.9	100.0%	11.3	100.0%	6.6	100.0%
ESI (includes Military)	8.9	49.7%	3.6	31.5%	5.4	80.9%
Through mother/step-father	5.8	32.3%	2.1	18.2%	3.7	56.4%
Through mother	4.6	25.4%	1.8	16.2%	2.7	41.1%
Through step-father	1.2	6.9%	0.2	2.0%	1.0	15.3%
Through nonresident father	2.3	12.7%	1.2	10.7%	1.1	16.2%
Through other/unknown	0.8	4.7%	0.3	2.6%	0.5	8.2%
Medicaid/SCHIP/State	5.9	32.9%	5.4	47.6%	0.5	7.6%
Other Insurance	0.5	3.0%	0.3	2.9%	0.2	3.2%
Uninsured	2.6	14.5%	2.0	18.0%	0.6	8.4%

Notes: Sample consists of 9,189 children living with their biological/adoptive mothers and *not* living with their biological/adoptive fathers. Percent figures may not sum to 100 due to rounding.

Source: Urban Institute analysis of the 1999 National Survey of America's Families (NSAF)

percent here). Her 1993 SIPP estimate reflects ESI through a non-resident father *at some point in the prior year,* while the NSAF estimate is the share who *currently* have ESI. (She also found that less than half of the fathers providing *any* coverage in the prior year provided it for the *entire* year, suggesting that an "ever last year" measure will greatly exceed a "current" measure.) Similarly, her uninsured measure reflects the share of children uninsured *for an entire year* (6 percent) while the one reported here (15 percent) is the share who are *currently* uninsured, a point-in-time estimate. There are several other differences between this and Wheaton's study. First, children with multiple sources of ESI are treated differently. Wheaton put "outside the household" first in her hierarchy, while this analysis puts ESI through a resident mother first, followed by coverage by a resident step-father, and finally by someone outside the household. Adopting a hierarchy similar to Wheaton's increases the NSAF estimate of children with ESI through a non-resident father from 13 to 16 percent. Second, Wheaton analyzed non-resident *fathers* while the NSAF analysis reported here is based on child support-eligible *children*. To the extent that the distribution of children is different from the distribution of fathers, there will be differences in reported coverage. If non-resident fathers with ESI coverage have relatively *fewer* children compared to those without ESI coverage, then estimates of ESI coverage based on fathers will be *higher* than those based on children. Conversely, if non-resident fathers with ESI coverage have relatively *more* children compared to those without ESI coverage, then ESI estimates based on fathers will be *lower* than those based on children. It is difficult to know from the NSAF data whether the observed differences between the two studies are the result of these methodological differences or true changes over time in the health care coverage of child support-eligible children.

Consistent with the differences in the employment characteristics of custodial mothers, the current health insurance profile of child support-eligible children living with their mothers differs by income. Less than a third of the children in low-income families have employer-sponsored health insurance compared to more than 80 percent of those in higher-income families. Most of this difference is due to coverage through the resident mother (16 versus 42 percent) followed by step-fathers (2 versus 16 percent). Non-resident fathers account for a relatively small share of

the difference between the two groups: 11 versus 17 percent of each group of children, respectively. As one might expect, children with family incomes below 200 percent of the federal poverty level are much more likely than children in higher-income households to have Medicaid/SCHIP/state coverage (48 versus 8 percent) and to be uninsured (18 versus 8 percent).

A more detailed look at employer-sponsored health insurance is presented in Figures 3 and 4. Figure 3 covers the 14.1 million children living in single-mother households, while Figure 4 looks at the remaining 3.8 million children in two-parent households, in this case children living with their biological or adoptive mother and her spouse, who is not the child's father.

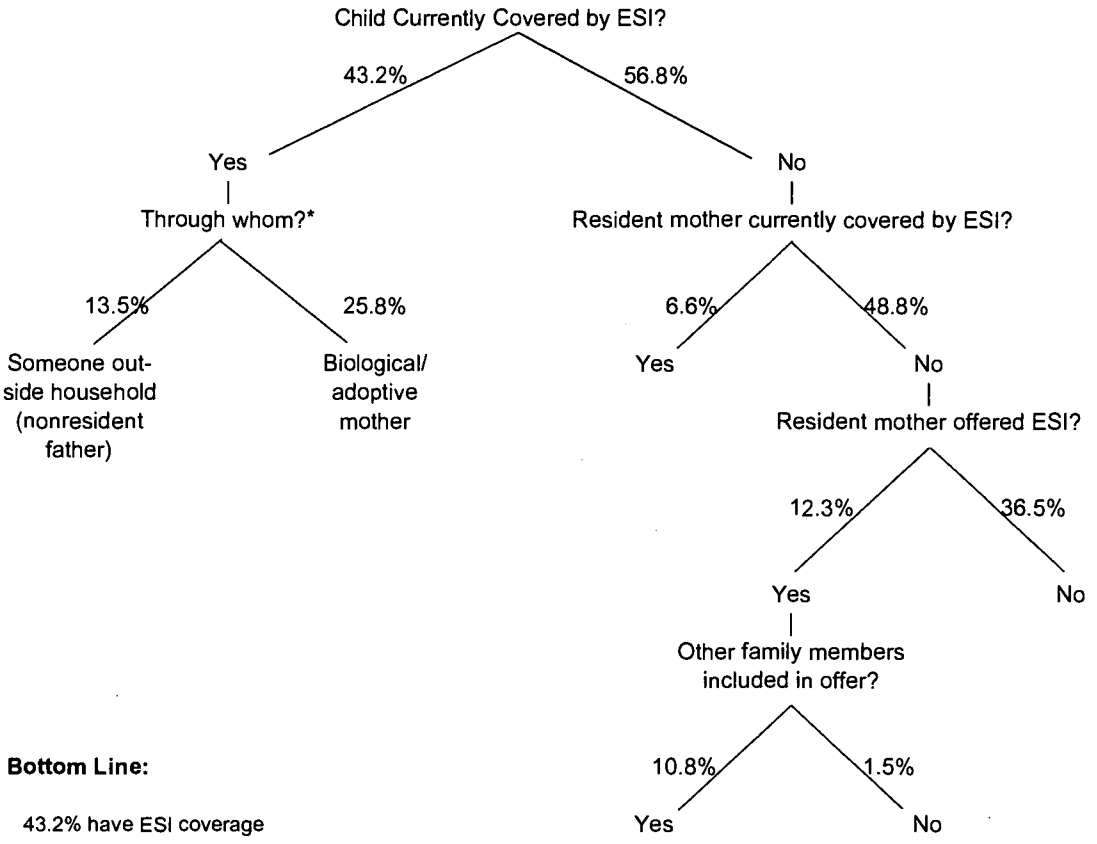
Less than half (43 percent) of children in the single-mother households are currently covered by ESI. The most common source of this coverage is through the resident mother's employer (26 percent of children). Non-resident fathers appear to provide 14 percent of child support-eligible children living in single-mother families with ESI coverage.[31] The right-hand side of Figure 3 sheds some light on the potential for securing ESI coverage through the resident mother for the 57 percent of children in single-mother homes that do not currently have such coverage. Most of these children have mothers who report that they themselves are not covered by ESI (50 percent of children in the single-mother sample) and the remaining 7 percent report having ESI coverage themselves but not for their child. When a mother has ESI herself but her child does not, the NSAF data do not indicate whether the ESI she has is also available for her children, but the likelihood is that it is. The availability of ESI coverage among mothers who are not themselves covered by ESI needs to be discussed in more detail.

Adult respondents to the 1999 NSAF survey who reported *not* being covered by ESI were asked the following question: "Does [your] current employer offer health insurance to workers in the same position as [yours]?" If so, they were then asked: "Does the health insurance offered by [your] employer also cover other family members besides the worker?" The first question was designed to determine if *the job* held by the respondent typically included an offer of health

[31] Note that this is the share of children with actual ESI coverage through their non-resident fathers. Other children may have other types of coverage that is *subsidized* by their non-resident fathers.

Figure 3

Employer-Sponsored Health Insurance (ESI)
Among Child Support-Eligible Children Living in Single-Mother Families



Bottom Line:

43.2% have ESI coverage
6.6% have no ESI coverage but appear to have access
10.8% have no ESI coverage and unlikely to have access
38.0% have no ESI coverage and no access

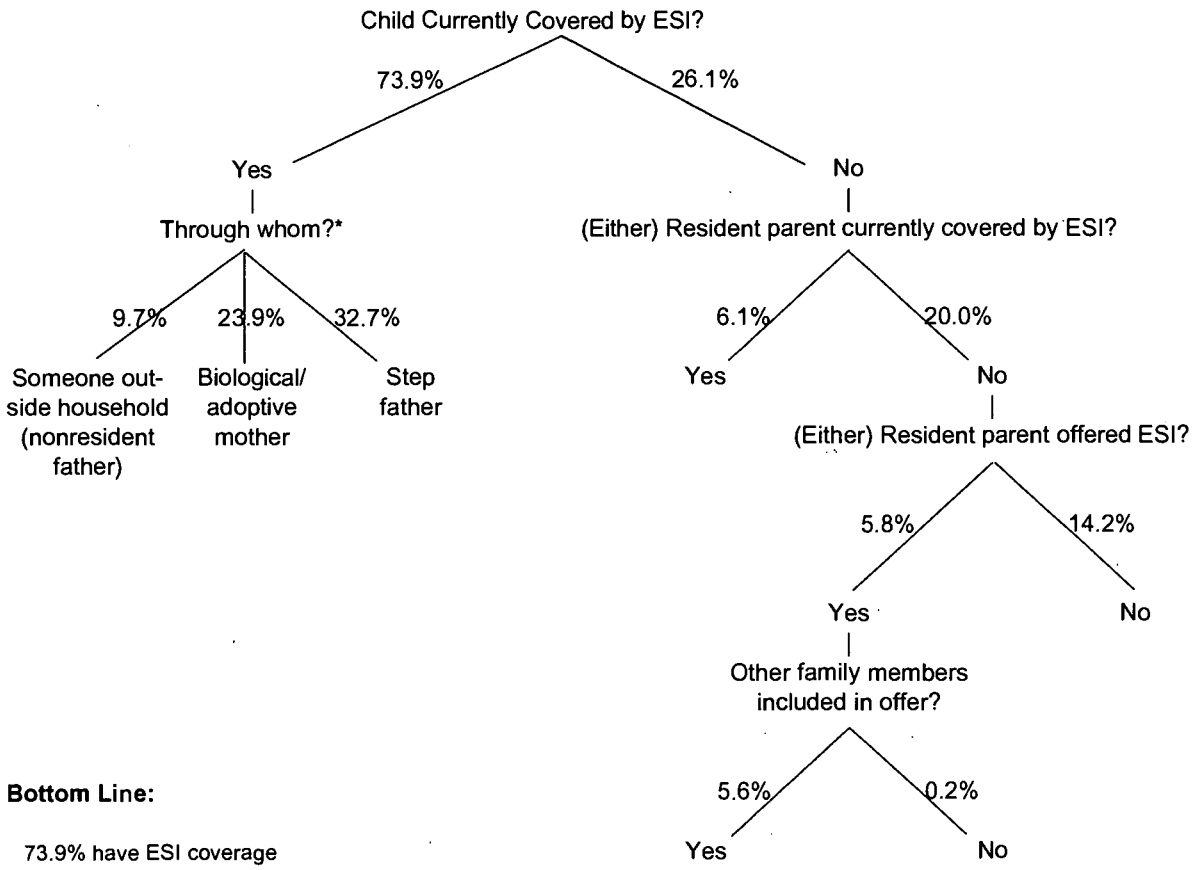
* Another 3.9 percent of children have the following other sources of ESI coverage: other adult in household (2.4%), Military insurance (source unknown,0.4%), and ESI source unknown (1.1%).

Notes: The following hierarchy was used for health insurance status: (1) ESI, (2) Medicaid/SCHIP or other state-sponsored coverage, and (3) other (including Medicare, privately purchased coverage, and other coverage that is not classifiable elsewhere). Children with both ESI and any other form of insurance were classified as having ESI. SCHIP eligibility is income eligibility only. See Appendix Figure 3 for corresponding numbers (in millions).

Source: Urban Institute analysis of 1999 National Survey of America's Families (NSAF).

Figure 4

Employer-Sponsored Health Insurance (ESI)
Among Child Support-Eligible Children Living with Their Mothers in Two-Parent Families



Bottom Line:

73.9% have ESI coverage
6.1% have no ESI coverage but appear to have access
5.6% have no ESI coverage and unlikely to have access
14.4% have no ESI coverage and no access

* Another 7.6 percent of children have the following other sources of ESI coverage: other adult in household (3.8%), Military insurance (source unknown, 3.7%), and ESI source unknown (0.1%).

Notes: The following hierarchy was used for health insurance status: (1) ESI, (2) Medicaid/SCHIP or other state-sponsored coverage, and (3) other (including Medicare, privately purchased coverage, and other coverage that is not classifiable elsewhere). Children with both ESI and any other form of insurance were classified as having ESI. SCHIP eligibility is income eligibility only. See Appendix Figure 4 for corresponding numbers (in millions).

Source: Urban Institute analysis of 1999 National Survey of America's Families (NSAF)

insurance, even if the individual respondent had not (yet) been offered health insurance—either because there was some type of waiting period, because the employee was known to have some other form of coverage, or for some other individual-specific reason. Thus, this measure reflects the percentage of individuals in jobs that generally include an offer of health insurance at some point in time, rather than the percentage of individuals with true offers of ESI. The NSAF measure may *overestimate* the latter, especially among lower-income respondents and/or recent hires. Data from the 1999 Current Population Survey (CPS), for example, indicate that the share of children living in single-*working*-mother households who have access to ESI coverage through the mother's employer is about 71 percent (61 percent of children in households below 200 percent of poverty, and 90 percent of children in other higher-income households).[32] The comparable figures from NSAF (limiting our sub-sample of children living with single mothers to working mothers) are 76, 70, and 88 percent, respectively.

The bottom portion of Figure 3 indicates that among the 50 percent of children whose mothers do not have ESI, one-quarter (12.5 of 49.5 percent) have mothers who report that workers like them are offered ESI, and most often this offers extends to other family members. The finding that most offers of ESI are extended to the employee's family is consistent with other nationally representative surveys looking at emplo yer-sponsored health insurance.[33]

In short, Figure 3 reveals that while 43 percent of child support-eligible children living in single-mother households are currently covered by ESI (two-thirds of them through their resident mother and one-third through their non-resident father), another 7 percent of children are not covered but may have access to ESI through their mother's employer (because she herself is covered and such offers usually extend to other family members). The remaining 50 percent of

[32] Analysis by Linda Blumberg of the Urban Institute of a merged file of the 1999 February and March Current Population Surveys.

[33] Data from the 1993 April Supplement to the Current Population Survey found that 74 percent of workers reported that their employer sponsors a health plan (67 percent reported that the plan offered employee and family coverage, 5 percent reported that the plan offered employee coverage only, and 2 percent didn't know whether or not the plan offered family coverage). Thus, 93 percent of those with offers reported that the offer included family coverage (U.S. Department of Labor 1994). The comparable rate for 1999 may be quite different.

children are unlikely to have ESI access: 39 percent clearly do not (because the mother has no ESI herself or if she does, it is not offered to her family members), and the other 11 percent of children have mothers who are offered ESI by their employers but do not actually buy into this coverage even for themselves. These data suggest that among child support-eligible children living in single-mother families who either have ESI or appear to have access to ESI, over 85 percent actually have ESI coverage, either through their mother or someone outside the household such as a non-resident father.[34]

Even a cursory glance at Figure 4 reveals how different child support-eligible children living with their mothers in two-parent households are from their counterparts in single-mother families. Close to three-quarters (74 percent) of these children are currently covered by ESI, compared to less than half of children in single-mother homes. And indeed, the source of this coverage (see the left-hand side of Figure 4) explains the difference between the two groups. Close to a third of children in this two-parent sub-sample (1.2 million children nationally) have ESI coverage through their step-parent. On the other measures, child support-eligible children living in two-parent families resemble those in the single-mother group. Three-quarters of the children not covered by ESI (20 percent of child support-eligible children living with their mothers in two-parent families) have parents who are also not covered by ESI, and less than a third of the children whose parents do *not* have ESI (6 percent of child support-eligible children living with their mothers in two-parent families) have parents with offers of such coverage. Among the small numbers who do, most have offers of family coverage.

In short, Figure 4 suggests that most (92 percent) of child support-eligible children living with their mothers in two-parent families who either have ESI or appear to have access to ESI, actually have the ESI coverage. Three-quarters of these children already have ESI coverage, and

[34] In a national survey of employers who offer coverage for dependent children, one in five (19 percent) reported that their employees decline such coverage. Most (62 percent) said this was done because the child(ren) were covered through a spouse's health plan, but almost a quarter (22 percent) said it was because the coverage was too costly. For employees with an average annual salary between $13,000 and $27,000 in 1998, the share was even higher: 28 percent of employers reported cost as a barrier to accepting dependent coverage (McManus and Fox 1999). Note that these findings are not limited to child support-eligible children.

another 6 percent of them do not have ESI but have mothers or step-fathers with this type of coverage. Securing ESI coverage for these children would mean that 80 percent of them would have ESI. The remaining 20 percent are unlikely to be able to have access to ESI. Two-thirds of these children have mothers (and step-fathers) who are not offered ESI, and the remaining third appear to have been offered it but do not opt for the coverage even for themselves.

While child support-eligible children living with their mothers in two-parent families are much more likely than those with single mothers to have ESI, the two groups are equally likely to be uninsured: 13-15 percent (see Table 5). The same cannot be said for Medicaid/SCHIP coverage—almost 40 percent of child support-eligible children in single-mother families have this type of coverage compared to 10 percent of children living with their mothers in two-parent families. This is likely to be due to the eligibility requirements for Medicaid and SCHIP.

Children's health insurance status varies by many characteristics other than family composition (see Table 5). ESI coverage increases as income increases (from 20 percent for children in families with incomes below 100 percent of the federal poverty level to 86 percent for children in families with incomes above 300 of the federal poverty level). At the same time, coverage by Medicaid/SCHIP declines with income. Children with mothers who are employed by the government and by non-profit organizations are most likely to have ESI (over 70 percent of these children do), and most often the source of this coverage is a parent in the child's own household. Children with mothers employed by private companies are somewhat less likely to have ESI (59 percent do). Non-resident fathers provide between 10 and 22 percent of children with ESI depending on what type of employer the mother works for.

Mother's occupation is strongly related to ESI coverage through a parent in the child's custodial household, but is unrelated to ESI coverage through the non-resident father. For example, the share of child support-eligible children living with their mothers with ESI coverage through their mother or step-father is 27 percent among children whose mothers work at a service job. This share climbs to 49 percent of children whose mothers work at administrative support or clerical

Table 5
Current Health Insurance Coverage of Child Support-Eligible Children Living with Their Mothers
by Various Socioeconomic Characteristics

	Employer-Sponsored Health Insurance (ESI) through:													
	mother or step-father		nonresident father		other		ESI Total		Medicaid/SCHIP		Other Insurance		No Insurance	
	(millions)	%	(millions)	%	(millions)	%	(millions)	%	(millions)	%	(millions)	%	(millions)	%
All Children	5.8	32.3%	2.3	12.7%	0.8	4.7%	8.9	49.7%	5.9	32.9%	0.5	3.0%	2.6	14.5%
Family Status														
single mother	3.6	25.8%	1.9	13.5%	0.6	3.9%	6.1	43.2%	5.5	38.9%	0.4	3.1%	2.1	14.8%
two parent family	2.2	56.7%	0.4	9.7%	0.3	7.5%	2.8	73.9%	0.4	10.4%	0.1	2.6%	0.5	13.1%
Family Income (% FPL)														
below federal poverty level	0.6	9.1%	0.6	9.5%	0.1	1.5%	1.3	20.1%	4.0	59.7%	0.2	2.5%	1.2	17.7%
100-199% FPL	1.5	33.0%	0.6	12.5%	0.1	3.0%	2.2	48.5%	1.4	29.7%	0.2	3.4%	0.8	18.4%
200-299% FPL	1.5	49.4%	0.6	19.2%	0.2	7.0%	2.3	75.5%	0.3	10.6%	0.1	2.4%	0.4	11.5%
at or above 300% FPL	2.8	64.9%	0.5	14.2%	0.2	6.4%	3.0	85.6%	0.2	4.9%	0.1	3.9%	0.2	5.6%
Mother's Employment Status														
currently employed	5.3	42.8%	1.8	14.4%	0.5	3.8%	7.6	70.0%	2.7	21.6%	0.4	3.1%	1.8	14.4%
full-time (35+ hrs)	4.6	52.4%	1.0	11.8%	0.4	4.0%	6.0	68.2%	1.6	17.6%	0.2	2.0%	1.1	12.3%
half-time (20-34 hrs)	0.4	20.4%	0.4	19.1%	0.1	3.9%	0.9	43.4%	0.7	35.3%	0.1	3.4%	0.4	17.9%
part-time (1-19 hrs)	0.1	18.5%	1.1	21.6%	0.0	2.5%	0.2	42.6%	0.2	35.1%	0.0	3.7%	0.1	18.6%
self-employed	0.2	17.7%	0.2	21.7%	0.0	2.5%	0.4	41.9%	0.2	20.3%	1.0	11.4%	0.2	26.4%
not currently employed	0.5	10.5%	0.5	9.6%	0.5	3.8%	1.2	22.8%	3.1	59.5%	0.1	2.8%	0.8	14.9%
looking for work	0.1	4.0%	0.1	8.1%	0.0	1.9%	0.3	14.0%	1.2	68.4%	0.0	2.4%	0.3	15.2%
not in the labor force	0.5	14.0%	0.3	10.5%	0.1	17.6%	0.9	27.7%	1.8	54.6%	0.1	3.0%	0.5	14.7%
Employer Type of Mother														
government	1.2	59.0%	0.2	10.3%	0.1	3.0%	1.5	72.3%	0.3	14.1%	0.0	1.8%	0.2	11.8%
private company	3.3	40.8%	1.1	13.8%	0.4	4.5%	4.8	59.2%	1.9	24.0%	0.2	2.3%	1.2	14.5%
non-profit organization	0.6	53.6%	0.2	17.1%	0.0	1.5%	0.9	72.2%	0.2	16.0%	0.0	2.1%	0.1	9.8%
other	0.2	17.5%	0.3	22.3%	0.0	2.2%	0.5	42.0%	0.3	24.3%	0.1	11.4%	0.3	22.4%
not working	0.5	10.5%	0.5	9.6%	0.1	2.8%	1.2	22.8%	3.1	59.5%	0.1	2.8%	0.8	14.9%
Occupation of Mother														
manager/prof/ technical	2.2	56.2%	0.6	15.8%	0.2	4.3%	2.9	76.3%	0.4	10.1%	0.1	3.8%	0.4	9.8%
sales	0.5	31.2%	0.2	14.6%	0.1	4.3%	0.8	50.0%	0.5	35.0%	0.0	2.6%	0.2	12.4%
admin support/clerical	1.3	49.2%	0.4	15.4%	0.1	4.2%	1.8	68.7%	0.5	18.4%	0.1	3.0%	0.3	9.9%
services	0.8	26.6%	0.3	11.7%	0.0	1.3%	1.1	39.7%	0.9	33.1%	0.1	3.7%	0.7	23.6%
other	0.7	40.2%	0.2	13.5%	0.1	5.6%	1.0	59.3%	0.3	21.5%	0.0	0.9%	0.3	18.3%
not employed now	0.5	10.5%	0.5	9.6%	0.1	2.8%	1.2	22.8%	3.1	59.5%	0.1	2.8%	0.8	14.9%
Industry of Mother														
agric/forestry/public admin	0.4	62.3%	0.1	9.9%	0.0	2.0%	0.5	74.2%	0.1	11.6%	0.0	2.1%	0.1	12.1%
construction	0.1	46.7%	0.0	6.7%	0.0	2.8%	0.1	56.1%	0.0	24.4%	0.0	0.7%	0.0	18.7%
manufacturing	0.8	52.4%	0.2	15.4%	0.1	5.0%	1.1	72.7%	0.2	14.9%	0.0	1.6%	0.2	10.8%
transprt/comm/public util	0.3	44.6%	0.1	12.8%	0.0	2.0%	0.4	59.4%	0.1	21.2%	0.0	2.9%	0.1	16.5%
wholesale / retail trade	0.7	28.4%	0.4	14.9%	0.1	4.6%	1.1	47.9%	0.8	33.8%	0.1	2.6%	0.4	15.7%
finance / ins / real estate	0.5	52.5%	0.2	17.7%	0.1	7.1%	0.7	77.3%	0.1	11.7%	0.0	2.8%	0.1	8.3%
services	2.6	42.5%	0.9	14.3%	0.2	3.0%	3.7	59.8%	1.3	20.9%	0.2	3.9%	1.0	15.4%
unspecified	0.0	49.3%	0.0	0.3%	0.0	8.8%	0.0	58.4%	0.0	21.8%	0.0	0.0%	0.0	19.8%
not employed now	0.5	10.5%	0.5	9.6%	0.1	2.8%	1.2	22.8%	3.1	59.5%	0.1	2.8%	0.8	14.9%
Firm Size (No. People at Work Place)														
under 10 people	0.5	32.1%	0.2	16.0%	0.1	4.3%	0.8	52.4%	0.4	28.0%	0.0	1.8%	0.3	17.8%
10-24 people	0.4	26.4%	0.2	15.5%	0.1	4.3%	0.7	46.1%	0.5	34.4%	0.1	4.1%	0.3	15.4%
25-99 people	0.9	42.3%	0.3	13.0%	0.1	3.3%	1.3	58.5%	0.5	22.2%	0.1	2.3%	0.4	16.9%
100-499 people	1.1	44.9%	0.4	15.7%	0.1	5.5%	1.6	66.0%	0.5	19.5%	0.0	1.7%	0.3	12.9%
500 people or more	1.1	64.0%	0.2	12.8%	0.0	2.4%	1.3	79.2%	0.2	13.4%	0.0	2.6%	0.1	4.8%
unspecified	1.4	44.8%	0.5	14.7%	0.1	2.8%	1.9	62.3%	0.5	17.0%	0.2	5.1%	0.5	15.6%
not working	0.5	10.5%	0.5	9.6%	0.1	2.8%	1.2	22.8%	3.1	59.5%	0.1	2.8%	0.8	14.9%
Paternity Established														
yes	5.4	34.5%	2.3	14.5%	0.6	3.9%	8.3	52.7%	4.7	30.2%	0.5	3.1%	2.2	14.0%
no	0.5	24.0%	0.0	1.4%	0.1	3.2%	0.6	28.6%	1.1	51.4%	0.0	2.1%	0.4	17.9%
Child Support Awarded														
yes	3.5	37.0%	1.6	17.1%	0.4	4.2%	5.6	58.3%	2.6	27.7%	0.3	3.4%	1.0	10.7%
no	2.4	28.6%	0.7	8.0%	0.3	3.4%	3.3	40.0%	3.2	38.8%	0.2	2.6%	1.5	18.6%
Any Child Support Received														
yes	3.0	37.2%	1.7	20.9%	0.4	4.7%	5.1	62.7%	1.9	22.8%	0.3	3.7%	0.9	10.8%
no	2.9	29.6%	0.6	6.1%	0.3	3.1%	3.8	38.8%	4.0	41.3%	0.2	2.4%	1.7	17.6%
Any Financial Contributions From Nonresident Father														
yes	3.5	35.2%	2.1	21.3%	0.5	4.9%	6.1	61.4%	2.4	24.0%	0.3	3.4%	1.1	11.2%
no	2.4	30.4%	0.2	2.2%	0.2	2.4%	2.8	35.0%	3.5	43.9%	0.2	2.4%	1.5	18.6%

Note: Sample consists of 9,189 children living with their biological/adoptive mothers and *not* living with their biological/adoptive fathers. Children in two parent families are those who have (re)married someone other than the child's father. "Other" ESI includes ESI though some "other adult" in child's household and Military coverage (source unknown). Percent figures may not sum to 100 due to rounding.

Source: Urban Institute analysis of 1999 National Survey of America's Families (NSAF)

jobs, and to 56 percent of children with mothers with managerial, technical, or other professional jobs. By contrast, the share of children covered by ESI through their non-resident fathers is between 12 and 16 percent irrespective of the mother's occupation. Medicaid/SCHIP coverage is greatest for children with low levels of ESI coverage, but a large share (almost one-quarter) of children with mothers working in service jobs are currently uninsured.

The industry in which a child's mother works also matters. Children with mothers in the financial/insurance/real estate, agriculture/forestry/public administration, and manufacturing industries enjoy the highest rates of ESI coverage (between 73 and 77 percent of child support-eligible children), while those with mothers working in wholesale or retail trade have among the lowest rates of employer-sponsored coverage (fewer than half of them). As with the mother's occupation, most of the *variation* in coverage comes through the child's custodial household rather than through non-resident fathers (who provide ESI for 7 to 18 percent of these children). ESI coverage, especially through the mother, also varies according to the number of employees working with the mother at her place of work. Half of children whose mothers work at sites with fewer than 25 people are covered by ESI. The share rises to two-thirds at sites where there are between 100 and 499 people and almost 80 percent when the mother works at sites with 500 or more workers.

Finally, the child support measures reported at the bottom of Table 5 show that better child support outcomes are positively associated with (but may not cause) better health insurance coverage outcomes. Compared to other child support-eligible children living with their mothers, those who have paternity established, are covered by a child support award, receive child support payments, and receive financial contributions from their non-resident father are considerably more likely to have ESI. Children with positive child support outcomes have among the highest rates of ESI coverage through non-resident fathers. Over 20 percent of children receiving any child support have this type of ESI, compared to 6 percent of other child support-eligible children. The comparable figures for children receiving any financial contributions from their non-resident fathers are 21 and 2 percent, respectively. These findings mirror those reported by

Wheaton (2000): while some fathers may be induced to provide health insurance as part of their overall child support obligations, it is also quite likely that those who pay child support are simply better able to also provide health insurance and may then be required to do so. State child support agencies are required to request that health coverage be included in the child support order when the custodial parent does not have private coverage and the non-resident parent has access to employment-based coverage (Wheaton 2000).

Health Insurance Coverage Over the Preceding 12 Months Among Child Support-Eligible Children Living with Their Mothers

Tables 6 through 8 report the number of months over the prior 12 months that child support-eligible children living with their mothers have had various types of health insurance. It is important to understand that these measures reflect some, but not all, aspects of stability of coverage. The data were reported as the total number of months (over the 12 month period preceding the month of the survey) that a child was covered by a given type of health insurance, *not* on a month by month basis, and so there is no information on the number or timing of changes (or disruptions) in coverage. Thus, even children with 12 months of ESI coverage prior to the month of the survey may have experienced changes in the *source* of coverage or other types of disruptions to this coverage, but the data will not reveal these.

Table 6 shows the numbers of months with health insurance coverage of any type, while Tables 7 and 8 present numbers of months with ESI and Medicaid/SCHIP, respectively. Over three-quarters (78 percent) of child support-eligible children living with their mothers have had some form of health insurance coverage in each of the past 12 months (see Table 6). Almost 10 percent have been uninsured for the entire year and the remaining 13 percent have had between one and eleven months of coverage.[35] The vast majority (over 90 percent) of children currently covered by ESI have had 12 months of health insurance coverage, and this is true whether the current source of coverage is the non-resident father or a parent in the custodial household. Over 86 percent of children currently covered by Medicaid/ SCHIP/State coverage have had a full year

[35] The categories of numbers of months of coverage were defined in this way because child support-eligible children tended to have either 0 or 12 months of coverage, while the remaining were evenly distributed across the middle (1 to 11) numbers of months.

Table 6
Health Insurance Coverage Over Preceding 12 Months:
Number of Months with Health Insurance of Any Type
Among Child Support-Eligible Children Living with Their Mothers

	0		1-11		12	
	(mils)	%	(mils)	%	(mils)	%
Total (all children, N=17.9 m)	**1.6**	**9.1%**	**2.3**	**12.9%**	**14.0**	**78.0%**
Current Health Insurance Status						
ESI through mother/step-father	0.0	0.0%	0.5	7.7%	5.5	92.3%
ESI through nonresident father	0.0	0.0%	0.1	4.1%	2.2	96.0%
ESI through other/unknown	0.0	0.0%	0.0	7.3%	0.6	92.7%
Medicaid/SCHIP/State	0.0	0.0%	0.8	13.4%	5.1	86.6%
Other insurance	0.0	0.0%	0.1	14.3%	0.5	85.7%
Uninsured	1.6	63.3%	0.8	32.5%	0.1	4.3%
Single-Mother Families (N=14.1 m)	**1.3**	**9.2%**	**1.9**	**13.3%**	**11.0**	**77.5%**
Current Health Insurance Status						
ESI through mother (or partner)	0.0	0.0%	0.3	7.6%	3.5	92.4%
ESI through nonresident father	0.0	0.0%	0.1	4.3%	1.9	95.7%
ESI through other/unknown	0.0	0.0%	0.0	11.0%	0.4	89.0%
Medicaid/SCHIP/State	0.0	0.0%	0.7	12.5%	4.8	87.5%
Other insurance	0.0	0.0%	0.1	14.8%	0.4	85.2%
Uninsured	1.3	61.8%	0.7	34.3%	0.1	3.9%
Two-Parent Families (N=3.8 m)	**0.3**	**9.1%**	**0.4**	**11.1%**	**3.0**	**79.7%**
Current Health Insurance Status						
ESI through mother/step-father	0.0	0.0%	0.2	7.9%	2.0	92.1%
ESI through nonresident father	0.0	0.0%	0.0	2.6%	0.4	97.4%
ESI through other/unknown	0.0	0.0%	0.0	2.2%	0.3	97.8%
Medicaid/SCHIP/State	0.0	0.0%	0.1	25.6%	0.3	74.4%
Other insurance	0.0	0.0%	0.0	12.4%	0.1	87.6%
Uninsured	0.3	69.5%	0.1	24.7%	0.0	5.8%
Below 200% FPL (N=11.3 m)	**1.3**	**11.5%**	**1.7**	**15.2%**	**8.3**	**73.3%**
Current Health Insurance Status						
ESI	0.0	0.0%	0.3	9.5%	3.2	90.5%
Medicaid/SCHIP/State	0.0	0.0%	0.7	12.5%	4.7	87.5%
Other insurance	0.0	0.0%	0.0	15.3%	0.3	84.7%
Uninsured	1.3	63.6%	0.7	32.5%	0.1	3.9%
200% FPL and above (N=6.6 m)	**0.3**	**5.2%**	**0.6**	**8.8%**	**5.7**	**86.0%**
Current Health Insurance Status						
ESI	0.0	0.0%	0.3	4.9%	5.1	95.1%
Medicaid/SCHIP/State	0.0	0.0%	0.1	23.3%	0.4	76.7%
Other insurance	0.0	0.0%	0.0	12.9%	0.2	87.1%
Uninsured	0.3	62.1%	0.2	32.3%	0.0	5.6%

Note: Sample consists of 9,189 children living with their biological/adoptive mothers and *not* living with their biological/adoptive fathers. Children in two-parent families are those with mothers who have (re)married someone other than the child's father. Percent figures may not sum to 100 due to rounding.

Source: Urban Institute analysis of 1999 National Survey of America's Families (NSAF)

Table 7
Health Insurance Coverage Over Preceding 12 Months:
Number of Months with Employer-Sponsored Health Insurance (ESI)
Among Child Support-Eligible Children Living with Their Mothers

	0		1-11		12	
	(mils)	%	(mils)	%	(mils)	%
Total (all children, N=17.9 m)	**8.5**	**47.4%**	**1.4**	**8.0%**	**8.0**	**44.6%**
Current Health Insurance Status						
ESI through mother/step-father	0.0	0.0%	0.8	12.8%	5.2	87.2%
ESI through nonresident father	0.0	0.0%	0.1	6.2%	2.2	93.8%
ESI through other/unknown	0.0	0.0%	0.1	9.2%	0.6	90.8%
Medicaid/SCHIP/State	5.8	97.4%	0.2	2.3%	0.0	0.0%
Other insurance	0.5	95.3%	0.0	4.7%	0.0	0.0%
Uninsured	2.2	86.7%	0.3	11.1%	0.1	2.3%
Single-Mother Families (N=14.1 m)	**7.6**	**53.9%**	**1.0**	**7.2%**	**5.5**	**38.9%**
Current Health Insurance Status						
ESI through mother (or partner)	0.0	0.0%	0.5	12.0%	3.3	88.0%
ESI through nonresident father	0.0	0.0%	0.1	6.6%	1.8	93.4%
ESI through other/unknown	0.0	0.0%	0.1	13.7%	0.3	86.3%
Medicaid/SCHIP/State	5.4	97.4%	1.4	2.6%	0.0	0.0%
Other insurance	0.4	94.3%	0.0	5.7%	0.0	0.0%
Uninsured	1.9	88.4%	0.2	10.1%	0.0	1.5%
Two-Parent Families (N=3.8 m)	**0.9**	**23.1%**	**0.4**	**10.9%**	**2.5**	**65.9%**
Current Health Insurance Status						
ESI through mother/step-father	0.0	0.0%	0.3	14.2%	1.8	85.8%
ESI through nonresident father	0.0	0.0%	0.0	4.0%	0.4	96.0%
ESI through other/unknown	0.0	0.0%	0.0	3.1%	0.3	96.9%
Medicaid/SCHIP/State	0.4	97.4%	0.0	2.6%	0.0	0.0%
Other insurance	0.1	100.0%	0.0	0.0%	0.0	0.0%
Uninsured	0.4	79.3%	0.1	15.3%	0.0	5.4%
Below 200% FPL (N=11.3 m)	**7.4**	**65.2%**	**0.9**	**7.7%**	**3.1**	**27.1%**
Current Health Insurance Status						
ESI	0.0	0.0%	0.5	14.9%	3.0	85.1%
Medicaid/SCHIP/State	5.3	97.8%	0.1	2.2%	0.0	0.0%
Other insurance	0.3	92.6%	0.0	7.4%	0.0	0.0%
Uninsured	1.8	88.8%	0.2	9.7%	0.0	1.5%
200% FPL and above A76(N=6.6 m)	**1.1**	**16.9%**	**0.6**	**8.4%**	**4.9**	**74.7%**
Current Health Insurance Status						
ESI	0.0	0.0%	0.4	8.1%	4.9	91.9%
Medicaid/SCHIP/State	0.5	93.7%	0.0	6.3%	0.0	0.0%
Other insurance	0.2	99.6%	0.0	0.4%	0.0	0.0%
Uninsured	0.4	78.7%	0.1	16.3%	0.0	5.1%

Note: Sample consists of 9,189 children living with their biological/adoptive mothers and *not* living with their biological/adoptive fathers. Children in two-parent families are those with mothers who have (re)married someone other than the child's father. Percent figures may not sum to 100 due to rounding.

Source: Urban Institute analysis of 1999 National Survey of America's Families (NSAF)

Table 8
Health Insurance Coverage Over Preceding 12 Months:
Number of Months with Medicaid/SCHIP Coverage
Among Child-Support Eligible Children Living with Their Mothers

	0		1-11		12	
	(mils)	%	(mils)	%	(mils)	%
Total (all Children, N=17.9 m)	**10.3**	**57.6%**	**1.9**	**11.0%**	**5.6**	**31.4%**
Current Health Insurance Status						
ESI through mother/step-father	5.3	89.0%	0.2	4.4%	0.4	6.6%
ESI through nonresident father	2.0	85.1%	0.1	3.4%	0.3	11.5%
ESI through other/unknown	0.7	95.8%	0.0	2.3%	0.0	2.0%
Medicaid/SCHIP/State	0.0	0.0%	0.9	15.7%	5.0	84.3%
Other insurance	0.5	85.6%	0.1	14.1%	0.0	0.0%
Uninsured	2.0	76.5%	0.6	23.5%	0.0	0.0%
Single-Mother Families (N=14.1 m)	**7.2**	**50.6%**	**1.7**	**12.0%**	**5.3**	**37.4%**
Current Health Insurance Status						
ESI through mother (or partner)	3.3	86.4%	0.2	5.0%	0.3	8.7%
ESI through nonresident father	1.6	83.1%	0.0	3.5%	0.3	13.4%
ESI through other/unknown	0.4	92.7%	0.0	3.9%	0.0	3.4%
Medicaid/SCHIP/State	0.0	0.0%	0.8	14.8%	4.7	85.2%
Other insurance	0.4	82.6%	0.1	17.1%	0.0	0.0%
Uninsured	1.6	74.4%	0.5	25.6%	0.0	0.0%
Two-Parent Families (N=3.8 m)	**3.2**	**83.7%**	**0.3**	**6.9%**	**0.4**	**9.3%**
Current Health Insurance Status						
ESI through mother/step-father	2.0	93.6%	0.0	3.5%	0.1	2.9%
ESI through nonresident father	0.4	95.7%	0.0	2.9%	0.0	1.5%
ESI through other/unknown	0.3	99.9%	0.0	0.0%	0.0	0.1%
Medicaid/SCHIP/State	0.0	0.0%	0.1	27.5%	0.3	72.6%
Other insurance	0.1	99.2%	0.0	0.8%	0.0	0.0%
Uninsured	0.4	85.7%	0.1	14.3%	0.0	0.0%
Below 200% FPL (N=11.3 m)	**4.5**	**39.9%**	**1.6**	**14.6%**	**5.2**	**45.6%**
Current Health Insurance Status						
ESI	2.8	77.7%	0.2	7.1%	0.5	15.2%
Medicaid/SCHIP/State	0.0	0.0%	0.8	14.4%	4.6	85.6%
Other insurance	0.3	78.4%	0.1	21.5%	0.0	0.0%
Uninsured	1.5	73.1%	0.5	26.9%	0.0	0.0%
200% FPL and above (N=6.6 m)	**5.8**	**88.0%**	**0.3**	**4.8%**	**0.5**	**7.3%**
Current Health Insurance Status						
ESI	5.1	95.7%	0.1	1.0%	0.1	2.4%
Medicaid/SCHIP/State	0.0	0.0%	0.1	29.8%	0.4	70.2%
Other insurance	0.2	97.5%	0.0	2.6%	0.0	0.0%
Uninsured	0.5	89.2%	0.1	10.8%	0.0	0.0%

Note: Sample consists of 9,189 children living with their biological/adoptive mothers and *not* living with their biological/adoptive fathers. Children in two-parent families are those with mothers who have (re)married someone other than the child's father. Percent figures may not sum to 100 due to rounding.

Source: Urban Institute analysis of 1999 National Survey of America's Families

of coverage and the remaining 13 percent have had one to eleven months of coverage. The majority (63 percent) of children who are currently uninsured have had no coverage of any type over the prior 12 months, a third have had between one and eleven months of some type of coverage, and a very small share (4 percent) were covered by some form of health insurance for 12 months before becoming uninsured in the month of the survey.

With the exception of children currently covered by Medicaid/SCHIP, there are not large differences in past-year coverage by either single- versus two-parent family status or by income group. For children currently covered by Medicaid/SCHIP or other state-sponsored plans, those in single-parent families and those who are low-income are more likely to have been covered for the entire 12 month period than other child support-eligible children: 88 percent of those in single-parent families compared to 74 percent of those in two-parent families, and 88 percent of those below 200 percent of the federal poverty line versus 77 percent of higher-income children (see Table 6).[36] As Table 8 shows, the majority of children currently covered by Medicaid/SCHIP have had this type of coverage for the preceding 12 months and low-income children (including those in single-parent families) are more likely to qualify for and use this type of coverage continuously.

Just under half (45 percent) of child support-eligible children living with their mothers have had 12 months of ESI coverage prior to the survey (see Table 7). Note that the share with no months of such coverage over the past year is about the same: 47 percent. But this pattern changes when one examines it by either family type or income. Thirty-nine percent of the children in single-parent families have had 12 months of ESI coverage compared to two-thirds (66 percent) of children in two-parent families. Differences by income are even greater: 27 percent of children below 200 percent of the federal poverty level have had 12 months of ESI coverage compared to three-quarters (75 percent) of higher-income children. Among low-income children with current ESI coverage (just under a third of children in this income group), a very large share—85 percent—have had 12 months of this type of coverage. Although this is lower than the 92

[36] These findings are statistically significant at the 95 percent confidence level (using α=.05).

percent observed among ESI covered children who are at or above 200 percent of poverty, it is still very high given the children's family income.

Twelve-month history of Medicaid/SCHIP coverage is reported in Table 8. Almost a third of child support-eligible children living with their mothers have been covered by Medicaid/SCHIP for 12 months. For low-income children, the figure rises to 46 percent and the figure is 86 percent for children currently covered by Medicaid/SCHIP. While almost one-quarter of currently uninsured children have had some Medicaid/SCHIP coverage in the prior year, just over three-quarters have had no months of this type of coverage for the entire year.

Eligibility for Medicaid and SCHIP Among Child Support-Eligible Children Living with Their Mothers

Information provided by NSAF respondents was also used to estimate whether children would be eligible for Medicaid or SCHIP, if they applied. This was done by developing a detailed model designed to simulate the eligibility determination process that families go through when they apply for Medicaid or SCHIP.[37] The model first uses NSAF household survey data to create household units, and then identifies and retains only those individuals in the unit who would be considered in an actual eligibility determination process. Next it determines potential income and resource eligibility by applying the state Medicaid and SCHIP income and resource methodologies in effect as of August 1999 to the reported income and assets of the relevant household members. In the last step, children are classified into one of the following groups: (1) those potentially eligible for Medicaid, (2) those potentially eligible for SCHIP (including children in states that expanded Medicaid and/or states that created separate programs under SCHIP), and (3) those not potentially eligible for either program.[38] It should be noted, however, that some children estimated to be eligible for SCHIP may have access to ESI. Insurance status

[37] This eligibility simulation was done by Lisa Dubay and Jennifer Haley of the Urban Institute (see Dubay and Haley 2001).

[38] In many states, foreign-born non-citizens are ineligible for Medicaid or SCHIP. All such children are classified as ineligible by the simulation model, resulting in a lower bound estimate of the true number of children eligible for these programs.

was *not* taken into account in determining eligibility even though ESI coverage generally precludes SCHIP (but not Medicaid) eligibility.

The results of this eligibility determination simulation, as well as access to ESI as reported earlier, are presented in Table 9. Fifty-seven percent of child support-eligible children living with their mothers are estimated to have access to some type of ESI (through someone in their custodial household or through their non-resident father).[39] The same share of children (58 percent) are eligible for Medicaid and another 15 percent are eligible for SCHIP. These figures are quite different for children whose family incomes are above and below 200 percent of the federal poverty level. Among low-income children, 40 percent appear to have access to ESI, while 74 and 15 percent are eligible for Medicaid and SCHIP, respectively. The corresponding eligibility figures for children in higher-income households are 86 percent (ESI), 31 (Medicaid), and 15 percent (SCHIP). The bottom portion of Table 9 confirms the economic advantages enjoyed by child support-eligible children living with their mothers in two-parent families. Eighty percent of them are estimated to have access to ESI, compared to 51 percent of children in single-mother families.

Eligibility for Various Types of Health Care Coverage Among Uninsured Child Support-Eligible Children Living with Their Mothers

Table 10 presents potential sources of health care coverage for child support-eligible children living with their mothers who are currently uninsured. While 17 percent appear to have access to ESI through their mothers' employer, it is very important to remember that the NSAF data do not speak to the affordability, accessibility, or comprehensiveness of this coverage. ESI access also varies with family income: 14 percent of low-income uninsured children may have access to ESI compared to 26 percent of those with higher incomes.[40] Two-thirds of uninsured child support-eligible children living with their mothers are eligible for Medicaid and another 15

[39] Recall that access to ESI was not simulated but was estimated based on the child being currently covered by ESI or having a resident parent with ESI coverage. ESI access through the non-custodial father is only known if the child actually has this type of coverage. NSAF has no data on the health insurance status of individuals not residing in the respondent's household.

[40] These findings are statistically significant at the 95 percent confidence level (using α=.05).

Table 9

Access to ESI and Estimated Eligibility for Medicaid and SCHIP Among Child Support-Eligible Children Living With Their Mothers

	All Children		ESI		Medicaid		SCHIP	
	(mils)	%	(mils)	%	(mils)	%	(mils)	%
All Children	17.9	100%	10.1	56.8%	10.4	58.0%	2.7	14.9%
Below 200% FPL	11.3	100%	4.4	39.7%	8.4	74.1%	1.7	14.8%
200% FPL and above	6.6	100%	5.6	85.8%	2.0	30.5%	1.0	14.9%
One-Parent Family	14.1	100%	7.0	50.5%	8.4	59.3%	2.2	15.8%
Two-Parent Family	3.8	100%	3.0	80.0%	2.0	53.5%	0.4	11.3%

Notes: Sample consists of 9,189 children living with their biological/adoptive mothers and *not* living with their biological/adoptive fathers. Children in two-parent families are those with mothers who have (re)married someone other than the child's father. Eligibility for SCHIP reflects income eligibility only.

Source: Urban Institute analysis of 1999 National Survey of America's Families (NSAF)

Table 10

Access to ESI and Estimated Eligibility for Various Types of Health Care Coverage Among Currently Uninsured Child Support-Eligible Children Living with Their Mothers

	Child Eligible for:							
	ESI		Medicaid		SCHIP		ESI or Medicaid or SCHIP	
	(mils)	%	(mils)	%	(mils)	%	(mils)	%
All Uninsured Children	0.4	16.5%	1.7	66.2%	0.4	15.1%	2.2	85.6%
Below 200% FPL	0.3	13.8%	1.4	68.7%	0.3	15.1%	1.8	86.0%
200% FPL and above	0.1	26.3%	0.3	56.7%	0.1	15.5%	0.5	84.4%
One-Parent Family	0.3	15.7%	1.3	64.4%	0.4	17.0%	1.8	85.1%
Two-Parent Family	0.1	19.8%	0.4	73.3%	0.0	7.5%	0.4	87.8%

Note: Sample consists of children living with their biological/adoptive mothers and *not* living with their biological/adoptive fathers. Children in two-parent families are those with mothers who have (re)married someone other than the child's father. Eligibility for SCHIP reflects income eligibility only. Access to ESI and eligibility for Medicaid or SCHIP are not mutually exclusive.

Source: Urban Institute analysis of 1999 National Survey of America's Families

percent are financially eligible for SCHIP. (Recall that eligibility for Medicaid/SCHIP and access to ESI are *not* mutually exclusive, but enrollment in any private health insurance and enrollment in SCHIP *are* mutually exclusive.) The final column in Table 10 reports the share of uninsured children living with their mothers who appear to have access to ESI *or* to be eligible for Medicaid or SCHIP. Over 85 percent of uninsured child support-eligible children living with their mothers are estimated to have access to or be eligible for some type of public or private coverage.

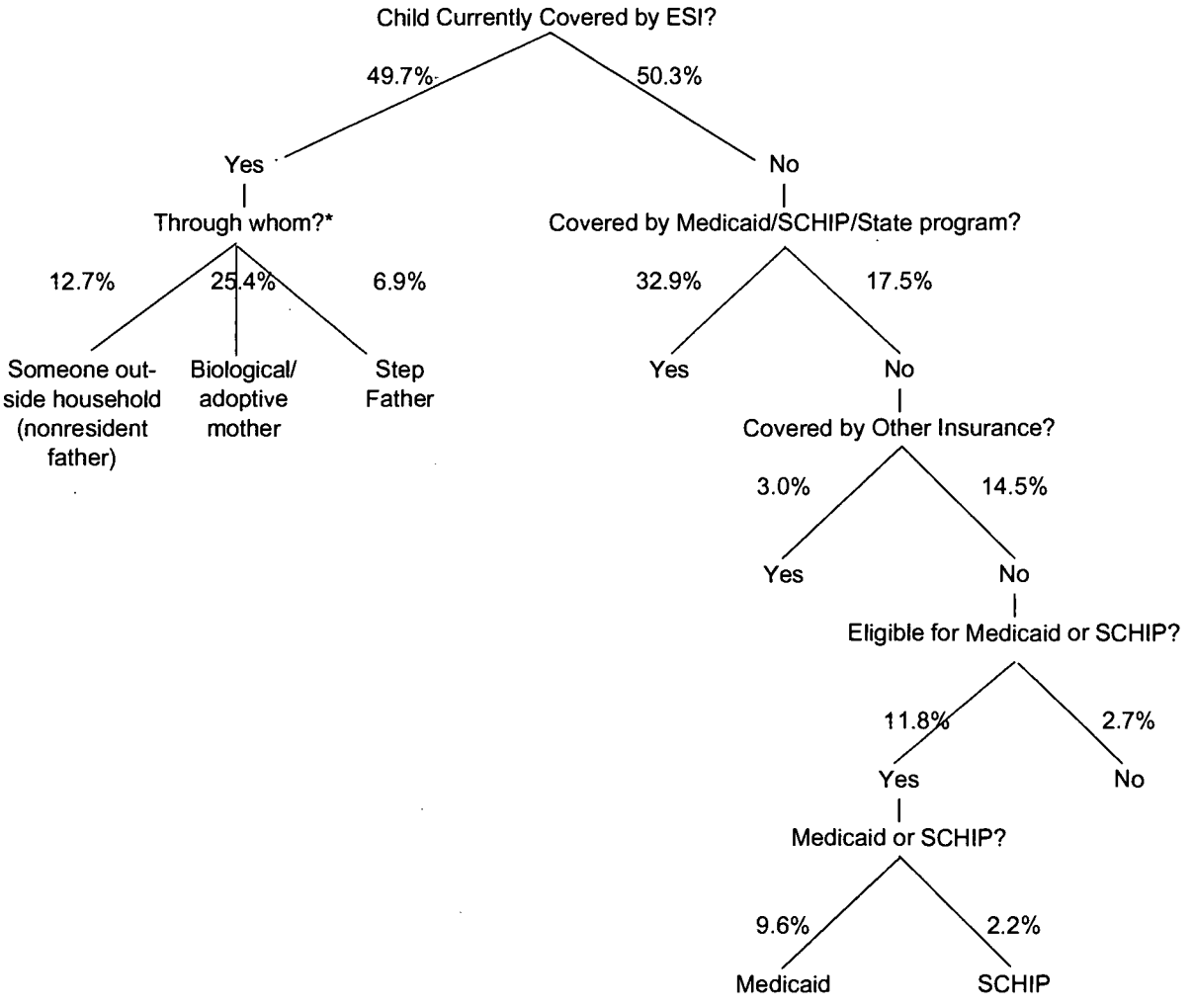
A summary of the health insurance profile of child support-eligible children living with their mothers, including their eligibility for Medicaid and SCHIP, is shown in Figures 5 through 7. Figure 5, which includes child support-eligible children living with their mothers in single- and two-parent families, shows that most children who are uninsured are eligible for Medicaid or SCHIP. The lower right-hand side of Figure 5 reveals that 2.7 percent of all child support-eligible children living with their mothers are both uninsured and *not* eligible for publicly-funded health insurance. As can be seen in Figures 6 and 7, this does not vary much by family structure.

Opportunities and Barriers to Coordination among IV-D, Medicaid, and SCHIP

The above analysis has demonstrated that untapped private health insurance through custodial mothers (and their spouses) could make modest increases in private coverage among child support-eligible children living with their mothers. The analysis further reveals that almost a quarter of child support-eligible children living with their mothers are either continuously uninsured or experience breaks in health insurance coverage during the year. Finally, the data reveal that a majority of currently uninsured child support-eligible children living with their mothers are eligible for, but not enrolled in, Medicaid and SCHIP. Those three findings, taken together, make clear that there are opportunities and compelling reasons for coordination between child support program staff and Medicaid and SCHIP program staff. Capitalizing on these opportunities would move the nation closer to making sure that whenever child support-eligible children cannot be insured through either parent, that public insurance steps in to fill the gap.

Figure 5

Overview of Health Insurance Coverage
Among Child Support-Eligible Children Living with Their Mothers



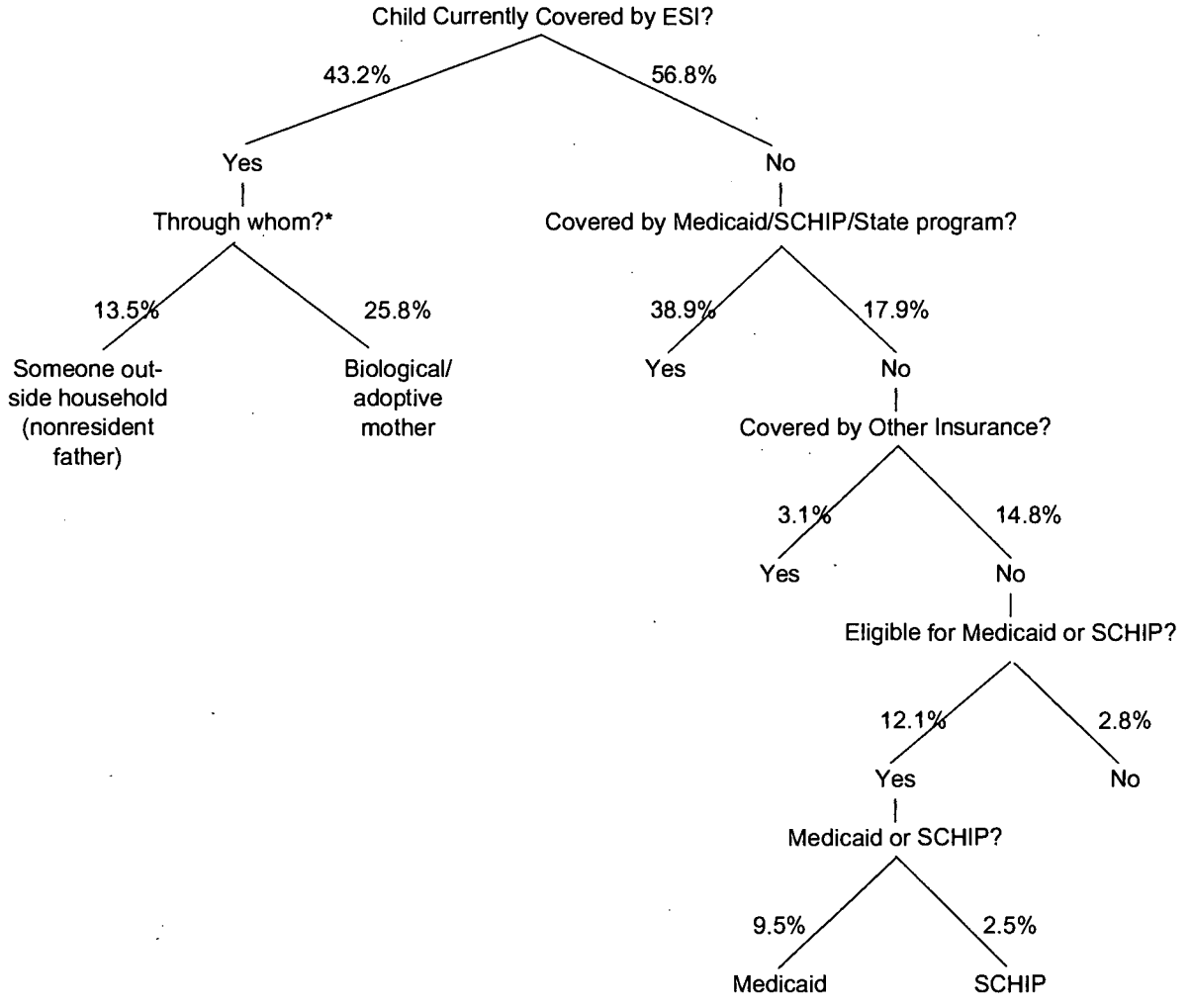
* Another 4.7 percent of children have the following other sources of ESI coverage: other adult in household (2.8%), Military insurance (source unknown, 1.1%), and ESI source unknown (0.9%).

Notes: The following hierarchy was used for health insurance status: (1) ESI, (2) Medicaid/SCHIP or other state-sponsored coverage, and (3) other (including Medicare, privately purchased coverage, and other coverage that is not classifiable elsewhere). Children with both ESI and any other form of insurance were classified as having ESI. SCHIP eligibility is income eligibility only. See Appendix Figure 5 for corresponding numbers (in millions).

Source: Urban Institute analysis of 1999 National Survey of America's Families (NSAF)

Figure 6

Overview of Health Insurance Coverage
Among Child Support-Eligible Children Living in Single-Mother Families



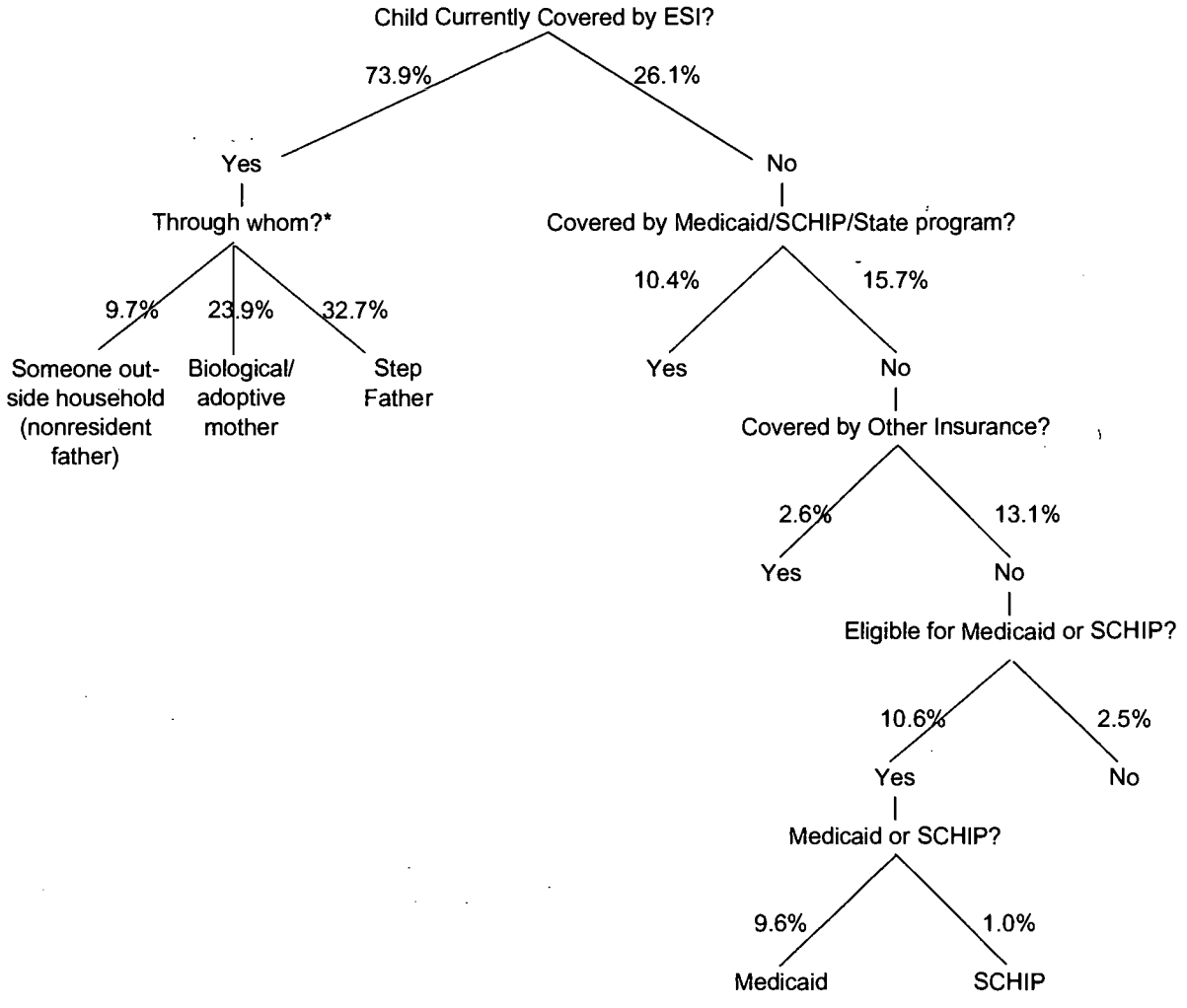
* Another 3.9 percent of children have the following other sources of ESI coverage: other adult in household (2.4%), Military insurance (source unknown,0.4%), and ESI source unknown (1.1%).

Notes: The following hierarchy was used for health insurance status: (1) ESI, (2) Medicaid/SCHIP or other state-sponsored coverage, and (3) other (including Medicare, privately purchased coverage, and other coverage that is not classifiable elsewhere). Children with both ESI and any other form of insurance were classified as having ESI. SCHIP eligibility is income eligibility only. See Appendix Figure 6 for corresponding numbers (in millions).

Source: Urban Institute analysis of 1999 National Survey of America's Families (NSAF)

Figure 7

Overview of Health Insurance Coverage
Among Child Support-Eligible Children Living with Their Mothers in Two-Parent Families



* Another 7.6 percent of children have the following other sources of ESI coverage: other adult in household (3.8%), Military insurance (source unknown, 3.7%), and ESI source unknown (0.1%).

Notes: The following hierarchy was used for health insurance status: (1) ESI, (2) Medicaid/SCHIP or other state-sponsored coverage, and (3) other (including Medicare, privately purchased coverage, and other coverage that is not classifiable elsewhere). Children with both ESI and any other form of insurance were classified as having ESI. SCHIP eligibility is income eligibility only. See Appendix Figure 7 for corresponding numbers (in millions).

Source: Urban Institute analysis of 1999 National Survey of America's Families (NSAF)

We interviewed officials from 9 states, most from child support agencies but some from Medicaid and SCHIP as well, to ascertain how much current opportunities for coordination were being exercised and what barriers officials perceive to coordination.[41] We found that officials perceived more barriers than opportunities to coordination.

Overall, officials noted that communication and referral occurs far more often from the Medicaid agency to the child support agency than vice versa, because Medicaid staff are trained in the requirement that custodial parents applying for Medicaid cooperate with child support as a condition of Medicaid eligibility. To that end, Medicaid staff routinely refer Medicaid applicants to the child support program. The cooperation requirement is embedded in both legislation and regulation, to ensure that custodial parents assign their rights to any non-custodial parent private health insurance reimbursement to the Medicaid agency.

Child support officials observed that their staff are not trained in Medicaid eligibility rules or benefits. Indeed, they offered that they would view a potential requirement to initiate coordination with Medicaid and SCHIP agencies as one that would exceed their mission and workload limits. They regard their mission as seeking and securing cash child support and employer-sponsored medical support from non-custodial parents. They regard their workload as already strained by the activities—locating non-custodial parents, establishing paternity, establishing child support orders, tracking payments, reviewing and modifying awards, initiating wage withholding and health insurance orders to employers—required to meet that mission, and by their large caseloads.

Finally, many respondents also observed that there is a philosophical difference between those working in the child support program and those in the SCHIP and Medicaid programs. While the child support program requires all of its clients to "cooperate" in identifying and locating fathers to enforce cash and medical support orders, the mission of SCHIP and Medicaid is to "cover kids"—to enroll eligible individuals. Respondents reported that most line workers

[41] These interviews were conducted by Lynne Fender of the Urban Institute. She is also the author of this summary of the interviews.

believe referring Medicaid applicants to child support agencies impedes that mission, because some mothers may abandon the Medicaid application process if they are required to cooperate with the child support enforcement agency in identifying their child's father.[42] Policymakers and program administrators may want to reexamine their agency's missions in the light of these perceived conflicts, address any apparent problems, and educate line workers accordingly.

Conclusions and Policy Implications

Half of the 17.9 million child support-eligible children living with their mothers are covered by private employer-sponsored health insurance (ESI), the primary source of health insurance in the U.S. Typically, this ESI coverage is through someone in the child's custodial household rather than a non-resident father (32 versus 13 percent of child support-eligible children living with their mothers, respectively). Another third of child support-eligible children living with their mothers—5.9 million children—rely on publicly-funded sources of health insurance, namely Medicaid, SCHIP, and other state-financed health care coverage programs. Finally, 15 percent (or 2.6 million) of these children are without any health insurance whatsoever.

- **Custodial mothers are an important source of ESI**

The NSAF analysis reported here clearly confirms the importance of ESI secured through custodial mothers. Custodial mothers are the single most important source of ESI for child support-eligible children living with their mothers, providing more than one-quarter of all such children with ESI. Twice as many children have ESI through their resident mothers than through their non-resident fathers: 26 versus 13 percent. Resident mothers provide half of all ESI coverage among children with such coverage and this is true of children in both low- and higher-income families. In low income families, custodial mothers provide 16 percent of coverage out of a total of 32 percent with ESI coverage. ESI coverage among children living with *higher-income* mothers is actually greater than ESI coverage among all child support-eligible children living with their fathers (81 percent versus 70 percent). Given that custodial fathers are also less likely to be low income than custodial mother families, it appears that ESI coverage by the

[42] It should be noted that there is no research evidence to support this assertion, only anecdotal evidence from SCHIP and Medicaid workers, as well as from advocacy organizations.

custodial parent family is likely to be affected by the income level of the family.[43] The higher the income of the custodial family, the more likely they are to provide ESI coverage for the children.

It is not known from the NSAF data whether resident mothers provide their children with ESI by choice or by necessity (because the non-resident father does not or cannot provide the coverage himself). The high rates of ESI coverage provided by custodial mothers may suggest that these mothers prefer to cover their children through plans offered by their own employers, because they are more familiar with the providers, benefits, and claims processing procedures. Non-resident fathers may contribute financially towards the costs of purchasing ESI through the resident mother's employer, but once again the NSAF data do not allow one to identify such contributions. However, child support policies often do not acknowledge such arrangements or recognize that custodial parents frequently do—and indeed may prefer to—provide ESI coverage, especially if the non-custodial parent contributes to the costs of this coverage.

- **Step-fathers also are an important source of ESI**

Another finding to emerge from the NSAF data is the importance of ESI coverage secured through the step-fathers. Other in-home coverage—step-parent coverage—makes up a significant share of ESI coverage among higher-income children (about 15 percent of higher-income children have ESI through a step-father) and non-custodial parents provide a similar share (16 percent) with ESI, making step-parent coverage almost as important in higher-income families as non-custodial parent coverage. For child support-eligible children living with their mothers in two-parent families (with a custodial mother who has either remarried or married for the first time) the single largest source of ESI coverage is step-fathers: one-third of these children have ESI through their step-father, while 24 percent have ESI through their resident mother, and 10 percent through their non-resident father.

[43] Thirty-six percent of child support-eligible children living with a resident father are low-income and 70 percent of them have ESI, compared to 63 percent of children living with a resident mother being low-income and 50 percent of them having ESI. Recall that child support-eligible children living with their fathers were excluded from this analysis.

Historically, step-parents have had no enforceable legal obligations to their step-children and further, not all employer-sponsored health plans extend their benefits to step-children. About 20 states, however, have made supporting step-children a statutory duty, at least while the step-parent is married to the child(ren)'s biological or adoptive mother (Medical Child Support Working Group 2000). The Working Group recommends as a best practice that "when neither parent has access to private health care coverage at reasonable cost but a step-parent does, enrolling the children in the step-parent's coverage should be considered under certain conditions." The findings reported here indicate that many step-parents are indeed able and willing to provide private health insurance coverage for their step-children. Some step-parents may already be providing family coverage for their biological children and their spouse, so there is no additional cost to add the step-child(ren).

- **Untapped ESI sources would increase children's ESI coverage rates very little**

NSAF data on ESI coverage among the custodial *mothers* of child support-eligible children were used to estimate how many children *without* ESI might have access to such coverage through their custodial mothers (and step-fathers). Recall that the main goal of Wheaton's paper (2000) was to estimate how much ESI coverage *non-custodial fathers* could provide. She found that ESI through non-custodial fathers might reduce the number of custodial families *without* private insurance by a minimum of 2 to 18 percent.[44] The reduction is so small because most non-resident fathers who have access to ESI coverage are also likely to have children who already have ESI access, often through another adult in the child's household.[45] Furthermore, the growing popularity of health maintenance organizations (HMOs) and other managed care arrangements means that the geographic distance between children and their non-resident parents is becoming an increasingly important barrier to accessing health care providers who participate

[44] The 2 percent figure is based on the percentage of non-custodial fathers who have access to ESI, while the 18 percent is based on those who have access *and* those who *possibly* have access to ESI.
[45] Wheaton's assumption that there is a large degree of overlap between non-custodial fathers with access to ESI and custodial mothers with access to ESI is based on the observation that women tend to partner with men of a similar or higher socioeconomic status. Furthermore, as Wheaton notes, many non-resident fathers may not provide health care coverage for their children precisely *because* the children are already covered under the custodial family's health care plan.

in these exclusive plans. Thus, even the small share of children who might be able to secure ESI through their non-resident fathers may not benefit from this coverage if they live far away from their fathers, or if the coverage is not continuous or too costly.

The NSAF data reveal that while 43 percent of child support-eligible children in single-mother families are currently covered by ESI, an additional 7 percent of these children may have access to ESI through their resident mothers, and the remaining 50 percent do not.[46] For children living with their mothers in two-parent households, 74 percent are currently covered by ESI, another 6 percent may have access to ESI, and the remaining 20 percent do not. Thus, untapped ESI through adults in the resident household might reduce the share of children without private health insurance by 12 percent among children in single-parent families and 23 percent for children in two-parent families. The latter figure is relatively high because the number of uninsured children in two-parent families is lower than the number in single-parent families. In general, like Wheaton's findings for ESI through non-custodial fathers, these reductions are not very large. They suggest that most child support-eligible children living with their mothers who have access to ESI actually have this coverage. With 6-7 percent of child support-eligible children living with their mothers appearing to have access to ESI but not having this coverage, however, there is still some room for improvement. One important reason why many parents who are offered ESI do not opt for this coverage for their children is the cost (Bennefield 1997, Cooper and Schone 1997). Large shares of child support-eligible children living with their mothers have no access to ESI and must rely on other sources of coverage if they are to be insured for their health care needs. These findings coupled with those of Wheaton show that ESI coverage rates can be increased by a very limited amount through untapped coverage through custodial and non-custodial parents. Most uninsured child support-eligible children need other sources of health care coverage.

[46] Access to ESI was estimated based on the child having a resident mother with ESI coverage. If a resident mother appeared to be offered ESI but did not actually have this type of coverage, then the child was *not* classified as having access to ESI.

- **Many child support-eligible children are eligible for Medicaid or SCHIP**

The NSAF data confirm that a majority of currently uninsured child support-eligible children living with their mothers are eligible for Medicaid or SCHIP. A detailed simulation model designed to mimic the actual eligibility determination process used for these programs found two-thirds of uninsured child support-eligible children living with their mothers to be eligible for Medicaid and another 15 percent eligible for SCHIP. Enrolling uninsured child support-eligible children living with their mothers in Medicaid or SCHIP when they are eligible for these programs would reduce the share of these children who are uninsured from 15 percent to 3 percent. Efforts are clearly needed to enroll more children who qualify for Medicaid, SCHIP, and other state-sponsored programs, and to ease transitions from one source of health insurance coverage to another (Kenney et al. 2001, Kenney and Haley 2001). New research also suggests that offering Medicaid/SCHIP coverage to (resident) *parents* may lead to greater shares of eligible *children* enrolling in these programs (Dubay and Kenney 2001).

- **Health insurance coverage, for those who have it, is generally stable over time**

Data on the 12-month history of health insurance coverage among child support-eligible children living with their mothers indicate that coverage is relatively stable (at least as it is measured here) among children who are insured. Even among the small share of children with ESI through their non-resident fathers, the vast majority (almost 95 percent) have had ESI coverage for all 12 months preceding the survey.[47] The 12-month coverage numbers for children currently covered by ESI through their resident mothers or who have publicly-funded coverage are similarly high (around 85 percent). Nonetheless, the multiplicity of the sources, the changes among the small but important minority of children who are currently insured, and the large changes among children who are currently uninsured point to the importance of considering *all* potential sources of health insurance coverage to reduce the number of uninsured children. This consideration needs to go beyond simply availability and/or eligibility, as was done in this analysis, to include the comprehensiveness, accessibility, and affordability of a given type of coverage.

[47] Recall that some changes, like changes in the source of ESI, are not captured by these data.

References

Acs, Gregory and Sandi Nelson, "'Honey, I'm Home.' Changes in Living Arrangements in the Late 1990s," Assessing the New Federalism, Policy Brief, No. B-38, The Urban Institute, Washington, DC, June 2001.

Bennefield, Robert L., *Health Insurance Coverage: 1996,* Current Population Reports, P60-199, U.S. Department of Commerce, Washington, DC, September 1997.

Broaddus, Matthew and Leighton Ku, "Nearly 95 Percent of Low-Income Uninsured Children Now Are Eligible for Medicaid or SCHIP," Center on Budget and Policy Priorities, Washington, DC, December 2000.

Committee on Ways and Means, U.S. House of Representatives, *The 2000 Green Book: Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means* (17th Edition), Washington, DC, October 6, 2000.

Cooper, Philip F. and Barbara Steinberg Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs 16:6,* November/December 1997.

Dubay, Lisa, Jennifer Haley, and Genevieve Kenney, "Children's Eligibility for Medicaid and SCHIP: A View from 2000," New Federalism, National Survey of America's Families, Policy Brief, Series B, No. B-41, The Urban Institute, Washington, DC, March 2002.

Dubay, Lisa and Genevieve Kenney, "Covering Parents Through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children," Kaiser Commission on Medicaid and the Uninsured, October 2001.

Edmunds, Margaret and Molly Joel Coye (eds.), *America's Children: Health Insurance and Access to Care*, National Research Council and Institute of Medicine, National Academy Press, Washington, DC, 1998.

Families USA Foundation, "Losing Health Insurance: The Unintended Consequences of Welfare Reform," Washington, DC, May 1999.

Federal Register, Vol. 63, No. 36, Department of Health and Human Services, Office of the Secretary, *Annual Update of the HHS Poverty Guidelines*, pp. 9235-9238, Washington, DC, February 14, 1998.

Health Care Financing Administration, "Supporting Families in Transition: A Guide to Expanding Health Coverage in the Post Welfare-Reform World," Administration for Children and Families, U.S. Department of Health and Human Services, March 1999.

Hoffman, Catherine and Alan Schlobohm, *Uninsured in America: A Chart Book*, Second Edition, The Kaiser Commission on Medicaid and the Uninsured, May 2000.

Kenney, Genevieve, Lisa Dubay, and Jennifer Haley, *Health Insurance, Access, and Health Status of Children, Findings from the National Survey of America's Families*, The Urban Institute, Washington, DC, October 2000.

Kenney, Genevieve and Jennifer Haley, "Why Aren't More Uninsured Children Enrolled in Medicaid or SCHIP?," Assessing the New Federalism, Policy Brief B-35, The Urban Institute, Washington DC, May 2001.

Kenney, Genevieve, Jennifer Haley, and Lisa Dubay, "How Familiar Are Low-Income Parents with Medicaid and SCHIP?, Assessing the New Federalism, Policy Brief B-34, The Urban Institute, Washington DC, May 2001.

Lyon, Matthew, "Characteristics of Families Using Title IV-D Services in 1997," U.S. Department of Health and Human Services, Office of the Assistant Secretary of Planning and Evaluation, Table 1, forthcoming 2002.

McManus, Margaret A. and Harriette B. Fox, "Private Health Insurance Coverage for Children: A Survey of 450 Employers," The Child Health Insurance Project, Report Number 1, Maternal and Child Health Policy Research Center, February 1999.

Medical Child Support Working Group, *21 Million Children's Health: Our Shared Responsibility*, Report to the Department of Health and Human Services and Labor, Washington, DC, June 2000.

Mills, Robert J., *Health Insurance Coverage: 2000*, Current Population Reports, P60-215, U.S. Census Bureau, September 2001.

O'Brien, Ellen and Judith Feder, "How Well Does the Employment-Based Health Insurance System Work for Low-Income Families?," Policy Brief, The Kaiser Commission on Medicaid and the Uninsured, September 1998.

Office of Child Support Enforcement, Administration for Children & Families, U.S. Department of Health and Human Services, *Child Support Enforcement FY 1999 Preliminary Data Report,* Washington, DC, August 2000.

Office of the Inspector General, U.S. Department of Health and Human Services, *Medical Insurance for Dependents Receiving Child Support*, OEI-07-97-00500, Washington, DC, June 2000.

Perry, Michael, Susan Kannel, R. Burciaga Valdez, and Christina Chang, *Medicaid and Children, Overcoming Barriers to Enrollment, Findings from a National Survey*, The Kaiser Commission on Medicaid and the Uninsured, January 2000.

Rice, Thomas et al., "Trends in Job-Based Health Insurance," UCLA Center for Health Policy Research, Los Angeles, CA, 1998.

Ross, Donna Cohen and Laura Cox, *Making It Simple: Medicaid for Children and CHIP, Income Eligibility Guidelines and Enrollment Procedures, Findings from a 50-State Survey*, The Kaiser Commission on Medicaid and the Uninsured/Center on Budget and Policy Priorities, Washington, DC, October 2000.

Scanlon, William J., "Health Insurance: Proposals for Expanding Private and Public Coverage," United States General Accounting Office Testimony Before the Committee on Finance, U.S. Senate, GAO-01-481T, Washington, DC, March 15, 2001.

U.S. Department of Labor, Social Security Administration, U.S. Small Business Administration, Pension Benefit Guaranty Corporation, *Pension and Health Benefits of American Workers: New Findings from the April 1993 Current Population Survey*, Washington, DC, 1994.

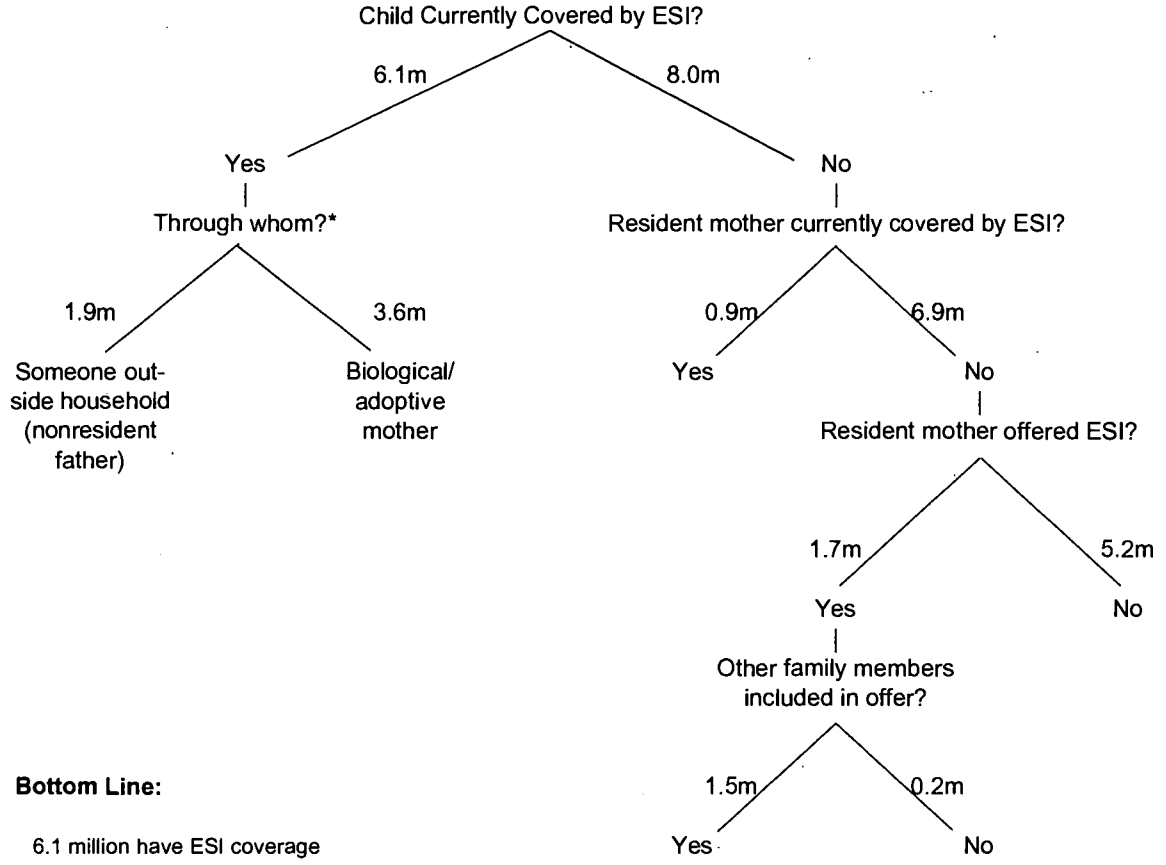
United States General Accounting Office, "Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures," Report to the Chairman, Committee on Labor and Human Resources, U.S. Senate, GAO/HEHS-97-122, July 1997.

Wang, K., D. Cantor, and N. Vaden-Kiernan, *No. 1: 1999 NSAF Questionnaire*, The Urban Institute, Washington, DC, February 2000.

Wheaton, Laura, "Nonresident Fathers, To What Extent Do They Have Access to Private Health Insurance?," Urban Institute Report to the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, DC, June 2000.

Appendix Figure 3

Employer-Sponsored Health Insurance (ESI)
Among Child Support-Eligible Children Living in Single-Mother Families
(number of children, in millions)



Bottom Line:

6.1 million have ESI coverage
0.9 million have no ESI coverage but appear to have access
1.5 million have no ESI coverage and unlikely to have access
5.4 million have no ESI coverage and no access

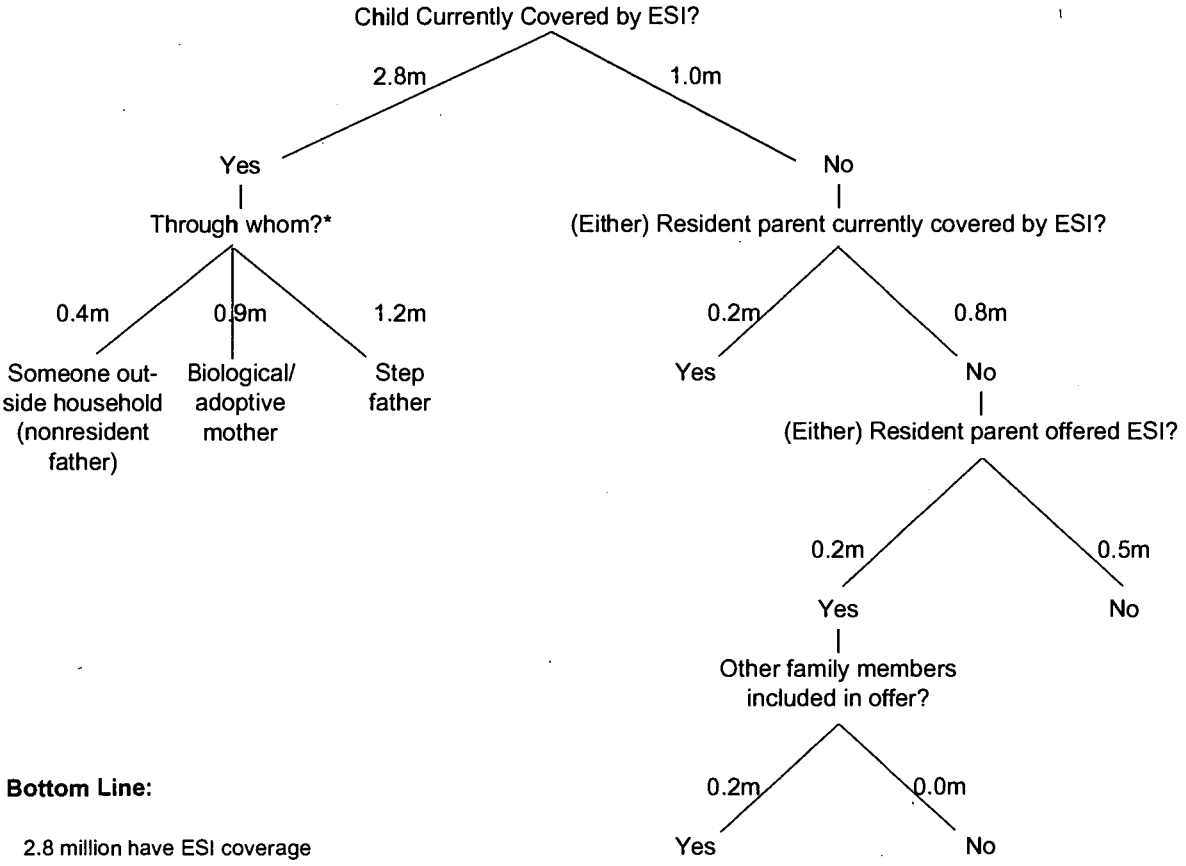
* Another 0.6 million children have the following other sources of ESI coverage: other adult in household (0.3m), Military insurance (source unknown, 0.1m), and ESI source unknown (0.2m).

Notes: The following hierarchy was used for health insurance status: (1) ESI, (2) Medicaid/SCHIP or other state-sponsored coverage, and (3) other (including Medicare, privately purchased coverage, and other coverage that is not classifiable elsewhere). Children with both ESI and any other form of insurance were classified as having ESI. SCHIP eligibility is income eligibility only. Numbers may not sum exactly due to rounding or missing data.

Source: Urban Institute analysis of 1999 National Survey of America's Families (NSAF)

Appendix Figure 4

Employer-Sponsored Health Insurance (ESI)
Among Child Support-Eligible Children Living with Their Mothers in Two-Parent Families
(number of children, in millions)



Bottom Line:

2.8 million have ESI coverage
0.2 million have no ESI coverage but appear to have access
0.2 million have no ESI coverage and unlikely to have access
0.5 million have no ESI coverage and no access

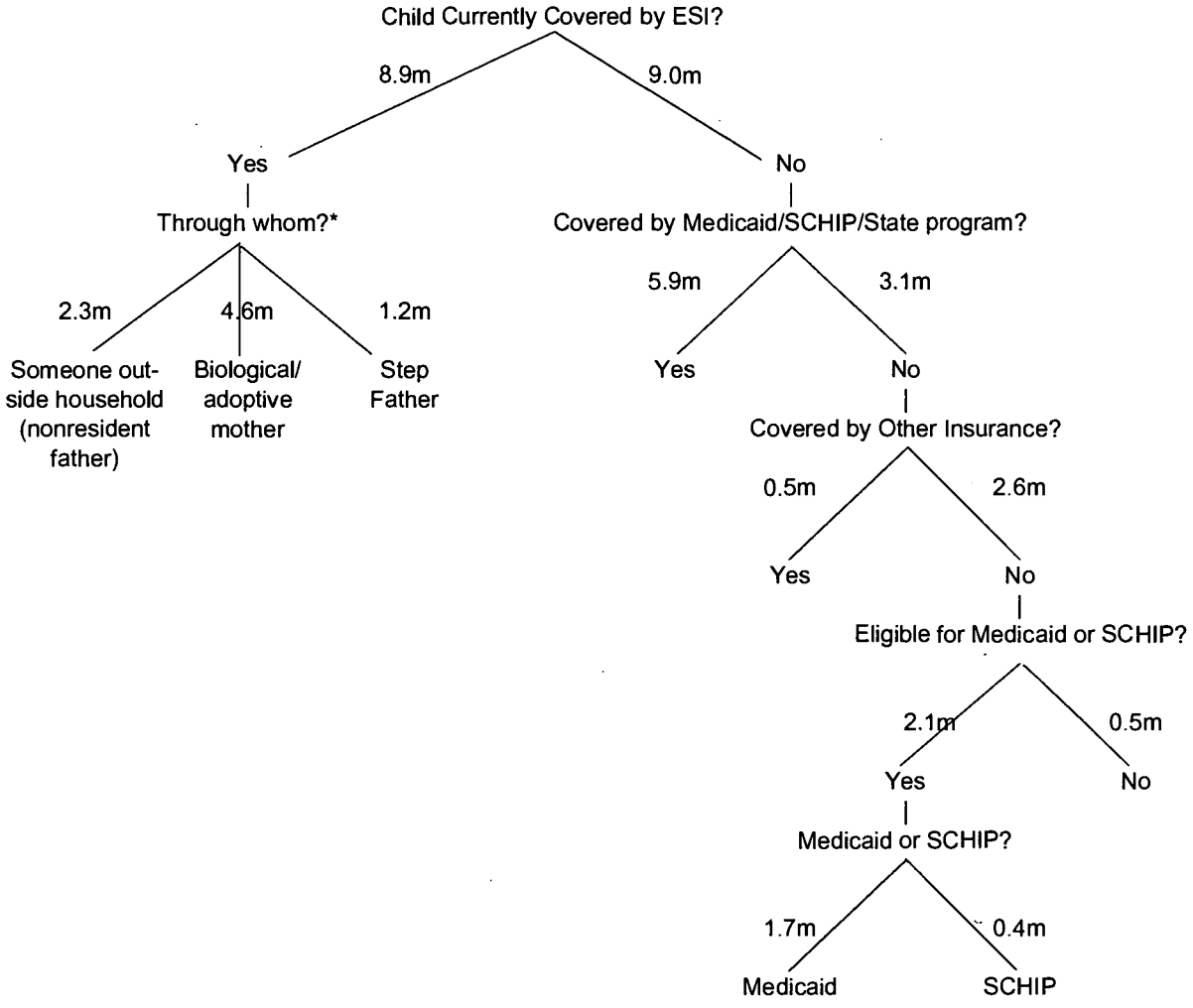
* Another 0.3 million children have the following other sources of ESI coverage: other adult in household (0.1m), Military insurance (source unknown, 0.1m), and ESI source unknown (0.0m).

Notes: The following hierarchy was used for health insurance status: (1) ESI, (2) Medicaid/SCHIP or other state-sponsored coverage, and (3) other (including Medicare, privately purchased coverage, and other coverage that is not classifiable elsewhere). Children with both ESI and any other form of insurance were classified as having ESI. SCHIP eligibility is income eligibility only. Numbers may not sum exactly due to rounding or missing data.

Source: Urban Institute analysis of 1999 National Survey of America's Families (NSAF)

Appendix Figure 5

Overview of Health Insurance Coverage
Among Child Support-Eligible Children Living with Their Mothers
(number of children, in millions)



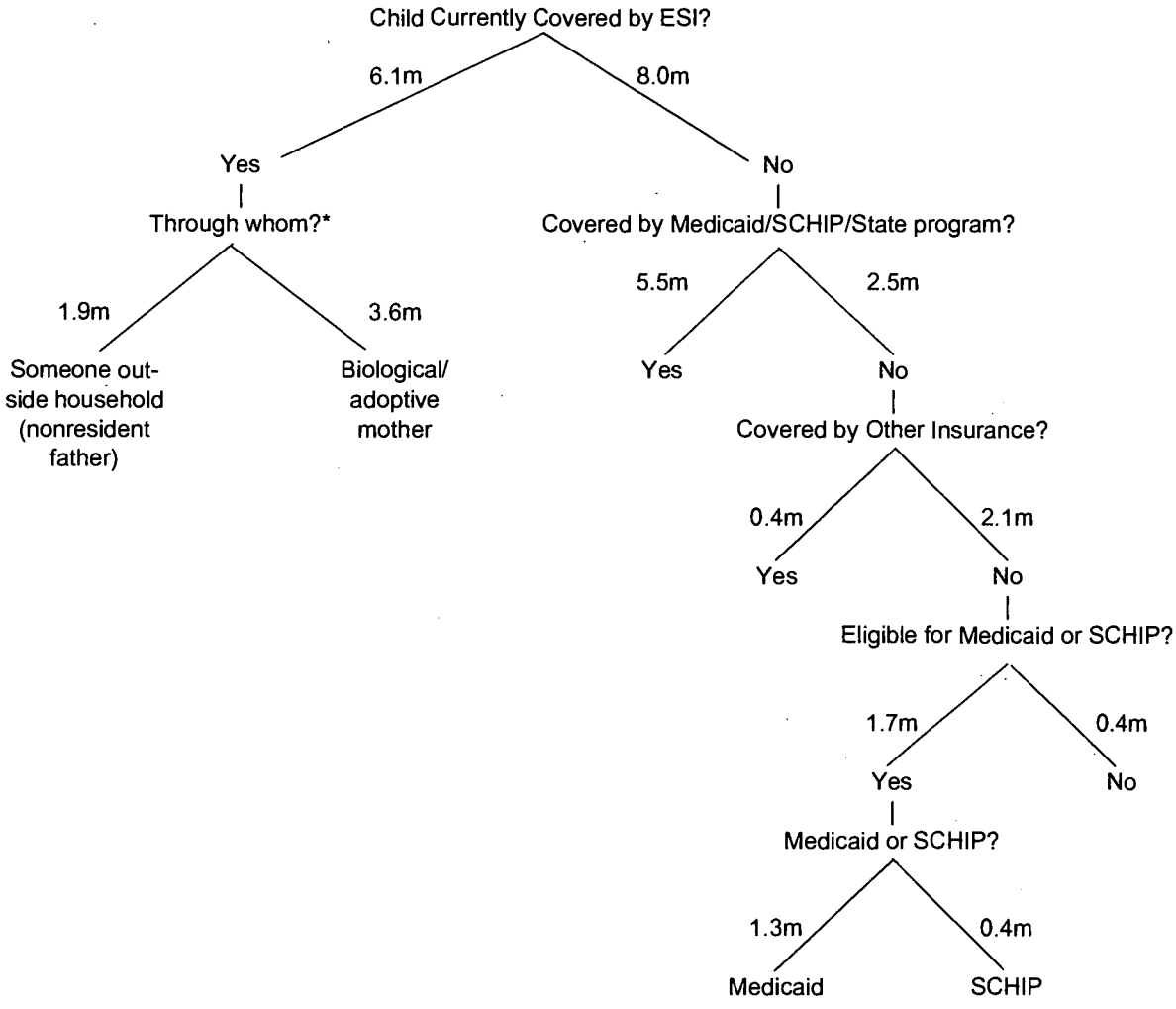
* Another 0.8 million children have the following other sources of ESI coverage: other adult in household (0.5m), Military insurance (source unknown, 0.2m), and ESI source unknown (0.2m).

Notes: The following hierarchy was used for health insurance status: (1) ESI, (2) Medicaid/SCHIP or other state-sponsored coverage, and (3) other (including Medicare, privately purchased coverage, and other coverage that is not classifiable elsewhere). Children with both ESI and any other form of insurance were classified as having ESI. SCHIP eligibility is income eligibility only. Numbers may not sum exactly due to rounding or missing data.

Source: Urban Institute analysis of 1999 National Survey of America's Families (NSAF)

Appendix Figure 6

Overview of Health Insurance Coverage
Among Child Support-Eligible Children Living in Single-Mother Families
(number of children, in millions)



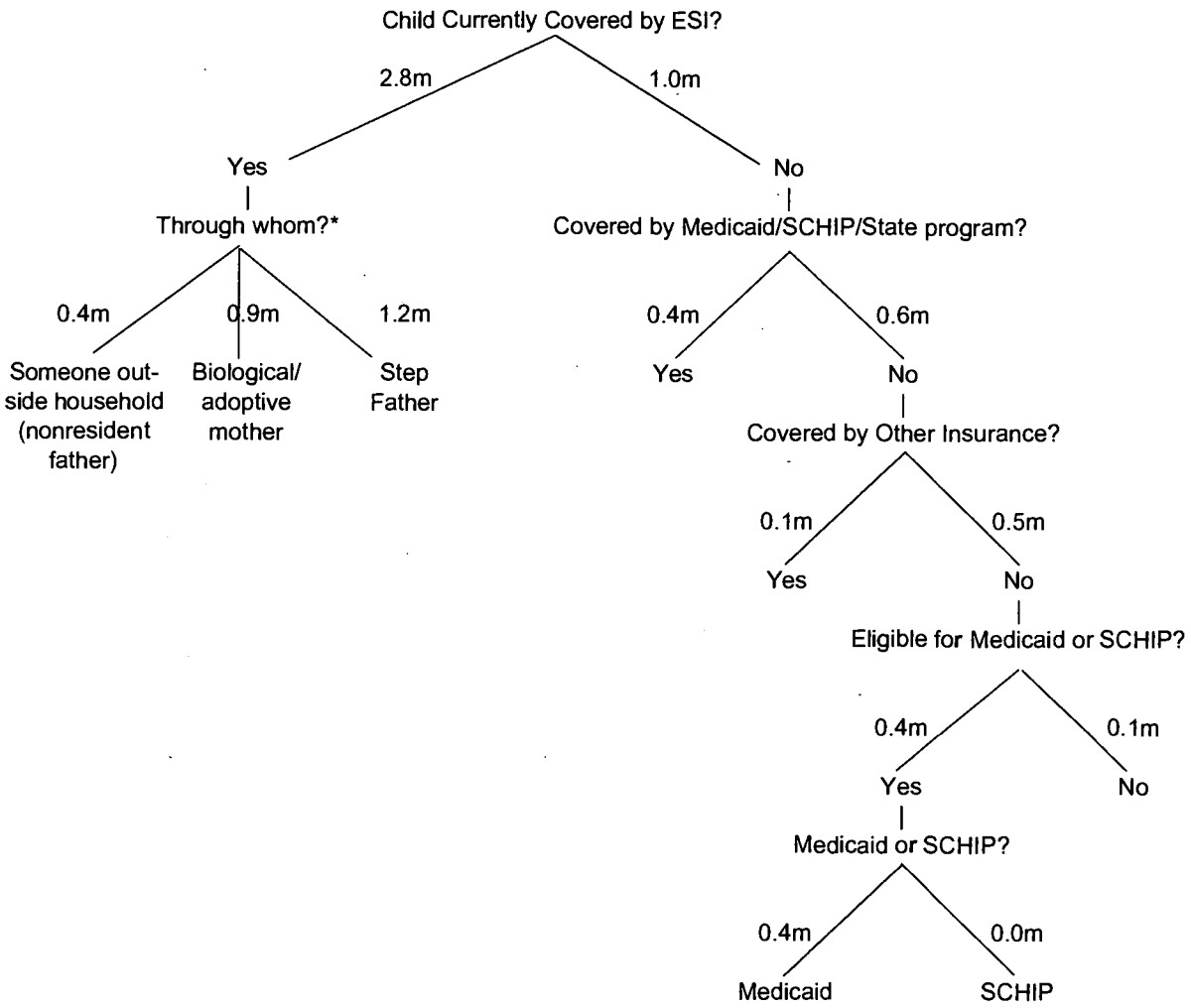
* Another 0.6 million children have the following other sources of ESI coverage: other adult in household (0.3m), Military insurance (source unknown, 0.1m), and ESI source unknown (0.2m).

Notes: The following hierarchy was used for health insurance status: (1) ESI, (2) Medicaid/SCHIP or other state-sponsored coverage, and (3) other (including Medicare, privately purchased coverage, and other coverage that is not classifiable elsewhere). Children with both ESI and any other form of insurance were classified as having ESI. SCHIP eligibility is income eligibility only. Numbers may not sum exactly due to rounding or missing data.

Source: Urban Institute analysis of 1999 National Survey of America's Families (NSAF)

Appendix Figure 7

Overview of Health Insurance Coverage
Among Child Support-Eligible Children Living with Their Mothers in Two-Parent Families
(number of children, in millions)



* Another 0.3 million children have the following other sources of ESI coverage: other adult in household (0.1m), Military insurance (source unknown, 0.1m), and ESI source unknown (0.0m).

Notes: The following hierarchy was used for health insurance status: (1) ESI, (2) Medicaid/SCHIP or other state-sponsored coverage, and (3) other (including Medicare, privately purchased coverage, and other coverage that is not classifiable elsewhere). Children with both ESI and any other form of insurance were classified as having ESI. SCHIP eligibility is income eligibility only. Numbers may not sum exactly due to rounding or missing data.

Source: Urban Institute analysis of 1999 National Survey of America's Families (NSAF)

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)

NOTICE

REPRODUCTION BASIS

☑ This document is covered by a signed "Reproduction Release (Blanket) form (on file within the ERIC system), encompassing all or classes of documents from its source organization and, therefore, does not require a "Specific Document" Release form.

☐ This document is Federally-funded, or carries its own permission to reproduce, or is otherwise in the public domain and, therefore, may be reproduced by ERIC without a signed Reproduction Release form (either "Specific Document" or "Blanket").